CourseBooks Series

Interviewing & Counseling

CourseBook

Spring 2018

Mark H. Kavanaugh, Ph.D. and Wendy St. Pierre, Ph.D.

The m-Learning Initiative

The multi-touch book that you have has been designed to house the content for a college course titled MHT 124: Psycho-social Rehabilitation at Kennebec Valley Community College. The course is part of KVCC's Mental Health Program which leads students to the attainment of the State of Maine's Mental Health Rehabilitation Technician / Community certification.

KVCC's Mental Health Program staff created the **m-Learning Initiative** and developed a 1:1 Apple iPad program. Curricula in the program has been geared to take advantage of the hard-ware and software tools of the iPad to:

- Enhance in-class teaching methods.
- Elevate assessment and evaluation of authentic artifacts that demonstrate student learning.
- Increase student-to-student interaction and student-to-teacher interaction.
- Prepare students for the mobile-computing based work-place emerging in Community Mental Health.

CourseBooks

The CourseBook series is a creation of Dr. Mark Kavanaugh. Dr. Kavanaugh created the Mental Health degree program at KVCC in 2006 and has taught in the program ever since.

This eBook series has been developed to enhance the delivery of course content across the entire program and take advantage of the tools within Apple's ecosystem in order to deliver more engaging course materials with embedded interactions, video, and links to apps and web content that support teaching and learning.

The content of these CourseBooks have been developed by the authors and represents independent scholarly activity on the part of each author who has contributed to the development of each CourseBook.

How to use this CourseBook

For the students within the Mental Health Program, the content of this CourseBook aligns with activities, expectations, and assignments that are found in the KVCC Learning Management System (LMS).

Students are expected to read and absorb the information in the CourseBook, review the Assessment expectations outlined in each Chapter, and participate in the expectations set by the Instructor of the course in the LMS.

Chapter Organization

Each (content) Chapter in the CourseBooks has been organized using the Instructional Design Method developed by Dr. Kavanaugh. This design model provides an outline of course materials that adheres to long-standing instructional design theory for adult learners. Namely, the model is greatly influenced by Gagne's Nine Events of Instruction.

ALOTA

The ID Method is called ALOTA.

ALOTA is an acronym for the four essential parts of a lesson plan (or, in this case, chapter).

Attention
Learning Outcomes
Teaching
Assessment

Each Chapter in the CourseBooks series is organized in this manner in order to guide students through the material they are expected to learn.

Here are brief descriptions of what you may find in each of these sections.

- **Attention**
  - Images, videos, and text that bring the reader into the focus of the lesson.
- **Learning Outcomes**
  - Adhering to the language of Blooms Taxonomy of Learning Objectives, this section outlines the performance-based learning outcomes for the lesson. These align with the Assessment section of each lesson.
- **Teaching**
  - This section can contain any variety of resources including text, lectures, recordings, videos, and links that provide a pathway through material to assist students in readying themselves for the Assessments.
- **Assessments**
  - This section outlines assignments for the student to engage in to demonstrate their learning.

Apps in the CourseBook

Because one of the central goals in the Mental Health Program is to develop advanced digital skills on mobile devices, we have included links to specific apps that students use in the context of their learning experiences.

These apps have been selected to enhance understanding of the material, to provide additional resources and information, and/or to challenge students to demonstrate their learning in innovative and creative ways.

In addition to direct links to the apps, there are additional links that have been included in the CourseBook that connect students to another resource in the CourseBook series.

When students encounter this button in a CourseBook...

...selecting it will open a corresponding chapter in a book titled **iOS and App Tutorials CourseBook**. This CourseBook has been designed to provide detailed introductions to and tutorials on all of the apps that have been integrated into the CourseBooks.

When you select this button for the first time you will be asked to download the **iOS and App Tutorials CourseBook** to your device.

Subsequent selections of the button will open the CourseBook to the corresponding chapter.

Download this book now by clicking the image of the CourseBook.

Text Link

Mental Health Core Content CourseBook

In order to remain consistent with some of the core content related to the courses in the Mental Health program, we have created an additional resources.

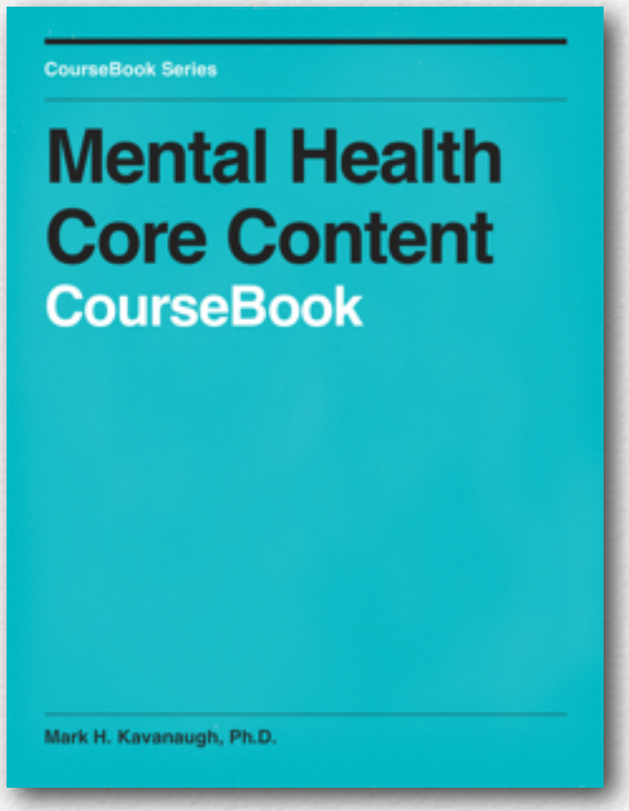
This CourseBook contains references to core concepts, material, practices, principles, standards, etc. that are used across every CourseBook and course in the program. Content in this reference will be accessed from within each CourseBook in a similar way you would access tutorials to apps in the iOS and App Tutorial CourseBook.

Look for this link when you are being guided toward looking at core content.

When you select this button for the first time you will be asked to download the **Mental Health Core Content CourseBook** to your device.

Subsequent selections of the button will open the CourseBook to the corresponding chapter.

Download this book now by clicking the image of the CourseBook.



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State of Maine MHRT/C Learning Outcome Guidelines

The content of this course is developed in line with the competency requirements for the State of Maine Mental Health Rehabilitation Technician / Community certification.

Below you will find a list of each of the Learning Outcomes associates with the competency and indication of the content and assessments related to those specific Learning Outcomes.

Competency - Interviewing and Counseling

Learning Outcomes and Content/Assessment Map

1. Understands family theory, developmental theory, human development across the lifespan, counseling theories, and crisis theory
    - *Chapter 2: Ethics and Multicultural Competence*
    - *Chapter 2 Discussion*
    - *Chapter 2 Assignment - Developmental Perspective*
    - *Chapter 8: Motivational Interviewing in Groups*
    - *Chapter 8 Assignment: Family Diagram*
2. Aware of prevalence and common effects of trauma.

- *Chapter 9: Emotions and Motivation*
- *Chapter 9 Discussion*

3. Aware of screening and assessment strategies for trauma.
    - *Chapter 9: Emotions and Motivation*
    - *Chapter 9 Discussion*
4. Aware of stages of recovery for survivors of trauma.
    - *Chapter 9: Emotions and Motivation*
5. Knowledgeable about etiology, progression, and treatment of major disabling conditions.
    - *Chapter 7: MI: Planning*
    - *Chapter 7 Discussion*
    - *Chapter 7 Assignment - My Own Treatment Plan*
6. Understands role of medication in symptom management.
    - *Chapter 5 Assignment - Focus on Medications*
7. Understands ethics and conducts practice in a professional manner.
    - *Chapter 2: Ethics and Multicultural Competence*
    - *Chapter 2 Discussion*
    - *Chapter 2 Assignment - Developmental Perspective*
    - *Chapter 8: Motivational Interviewing in Groups*
    - *Chapter 8 Assignment - Part I - Family Diagram and Part II - Intervention*
8. Aware of the need to evaluate effectiveness of personal practice.
    - *Chapter 3: Motivational Interviewing and Treatment Planning*
    - *Chapter 3 Assignment - MI Within Treatment Planning*
    - *Lab 1, Lab 2, Lab 3, Lab 4, and Lab 5*
9. Understands effective use of supervision.
    - *Chapter 3: Motivational Interviewing and Treatment Planning*
    - *Chapter 3 Assignment - MI Within Treatment Planning*
    - *Lab 1, Lab 2, Lab 3, Lab 4, and Lab 5*

Mark H. Kavanaugh, Ph.D.

Mark Kavanaugh has been writing, teaching, and integrating technology into instruction for decades. He holds a Masters in Counseling, Masters in Instructional and Performance Technology, and a Ph.D. in Educational Psychology.

Mark lives in Maine with his wife Katie.

Visit Mark's Website

Text Link

Interviewing and Counseling

Attention

Interviewing and Counseling

This first lesson is about getting oriented to the purpose of this course. The title of the course is "Interviewing and Counseling" and implies the use of verbal skills to engage your clients. While we do a lot more "interviewing" than we do "counseling" the skills needed for both of these processes are very similar. This Lesson will be an overview of why we need these skills.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss the importance of developing effective interpersonal skills in order to be an effective mental health worker.
2. Discuss the application of the skills learned in this course to the field of mental health.

Teaching

Why learn about Interviewing and Counseling?

As you make your way through the lesson plans in this course you will find that it is geared toward teaching you about the process of psychotherapy, which you will NOT be doing in your work! We teach this course in this manner because these skills are not only important in the process of psychotherapy but also in all of our interactions with others.

What is psychotherapy? Psychotherapy, or "talk therapy", is a way to treat people with a mental disorder by helping them understand their illness. It teaches people strategies and gives them tools to deal with stress and unhealthy thoughts and behaviors. Psychotherapy helps patients manage their symptoms better and function at their best in everyday life. Sometimes psychotherapy alone may be the best treatment for a person, depending on the illness and its severity. Other times, psychotherapy is combined with medications. Therapists work with an individual or families to devise an appropriate treatment plan (from http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml). An individual who considers him/herself a therapist may have a variety of different types of training. The person could have an education in psychology, individual counseling, marriage and family counseling, substance abuse counseling, pastor counseling (spirituality/religion), social work, art therapy, equine therapy (with horses), music therapy.... I think you get the idea. Just because the word therapist is used it is important to understand the training and education of the person using that term.

As mental health professionals we have the tools to not only enhance our relationships with our clients, but to enhance our relationships with everyone in our lives!

Why are interviewing and counseling skills important for an individual working as an MHRT/C? Some of the roles for MHRT/C's in Maine include these titles:

- Community Integration/Case Management
- Skills Development
- Residential Support Staff
- Day Support Services

- Assertive Community Treatment (ACT)
- Crisis Intervention
- Behavioral Health Support Staff
- Clubhouse Staff Members

In each of these roles you will be working one on one with individuals in their homes and communities. MHRT/C's regularly interact with clients, family members, friends of clients, and other service providers. Your ability to interact professionally with all of these individuals will be very important for your success in any of these roles. You will need to have the skills to know how to ask questions to gain relevant information, how to direct conversations to remain on task, how to assess for safety and sometimes how to de-escalate volatile situations.

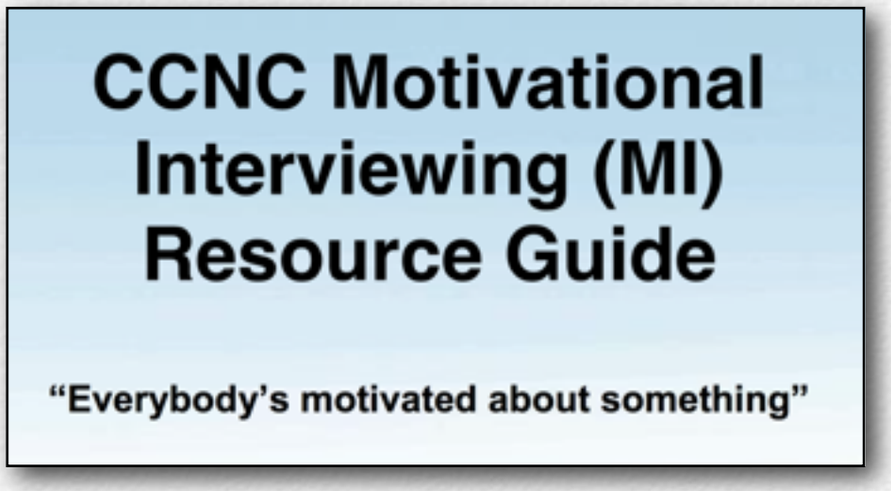
This course will provide you with some basic interviewing and counseling skills to enable you to complete future assignments such as collecting assessment information, determining an individual's level of risk (crisis assessment), conducting treatment planning, documenting interactions and communicating with others who are also involved in your clients' lives. It is always important to remember that every client you interact with is a person in his or her environment. Meaning the environment a person is from can affect how that person interacts with others.

Motivational Interviewing

In this course we are going to be learning about a model of interaction known as "Motivational Interviewing"

"Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language go change. I tis designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the persons' own reasons for change within an atmosphere of acceptance and compassion." - Miller and Rollnick (2012)

We will discuss the intricacies of this model in a future lesson but for now we can refer to the **CCNC Motivational Interviewing (MI) Resource Guide** for a basic explanation.



We will be using this guide throughout the course...click on the logo above to download this PDF.

Read pages 1-6 of this Guide. Take note of the following topics:

The "Spirit" of Motivational Interviewing

- Partnership
- Acceptance / Autonomy / Absolute Worth
- Compassion
- Evocation

Key Principles

- Express Empathy
  - Listening to the client without being judgmental, critical, or blaming. In the early stages a person may not be yet willing to give up their behaviors.
- Develop Discrepancy
  - Helping clients see a difference between what they are doing now and what they want to be in the future.
- Roll with Resistance
  - Resistance will happen. The key approach in MI is to "roll" with the resistance. Reflecting back to the client the emotions that you sense and using the resistance to further explore their commitment to change.
- Support Self-Efficacy
  - Self-efficacy is the perception we have of our ability to do or accomplish something. We work to build our clients' confidence in their ability to bring about change...this ability can then be used to bring about other changes as well.

Consider how the "Spirit" and "Key Principles" that you have just read about match your own personal ways of communicating. How useful, based on your current understanding, are these skills in working with people with mental illness?

Text Link

Assessment

Chapter 1 Discussion

Having excellent interpersonal skills is key to being a successful mental health worker. Be honest, how good are your conversational skills? Are you sometimes shy or introverted? Do you have trouble talking about specific topics?

How do you see the principles of Motivational Interviewing and the learning you will experience in this class impacting your work as a mental health worker?

For full credit in the graded discussions you need to post at least ONE response to the prompt in the Lesson and reply to at least TWO other students' posts. Your reply posts must be substantive. Please see the grading rubric in the Syllabus for this course for more details.

These instructions apply to all the graded discussions in this course and will not be repeated.

Ethics and Multicultural Competence

2

Attention

Ethics

Ethics embody a set of standards by which we make decisions. These guidelines often read like "laws" and even some of them have control systems (such as fines and punishments) when you do not comply with them, but they are designed to help guide your thinking about your practice. This thought process is what we are going to develop in this Lesson.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Identify standards of ethical practice
2. Understand the use of ethics in professional practice
3. Apply an understanding of cultural diversity and human developmental theory to personal practice

Teaching

American Counseling Association Code of Ethics

Many professional organizations construct of document that outlines the Professional Code of Ethics associated with that field. At the time of this writing, the State of Maine is putting together a Code of Ethics for Case Management and other Mental Health Community providers so soon we will have one of our own.

AMERICAN COUNSELING ASSOCIATION
Your Passion. Your Profession. Our Purpose.

In the meantime, we are going to borrow one from the American Counseling Association. Click HERE to download the **2014 ACA Code of Ethics.**

Using the Code to Guide your Practice

Most of the time we rely on our "gut instinct" to tell us if we are doing the "right" thing or not, but you will soon realize that this is not always a reliable source of information for decision making. Our gut is valuable, but it is also prone to patters of behavior (good and bad) and to perceptions shaped by our biases (culture, attraction, history, etc.)

Using the Code is sort of like using any set of guidelines to guide our behavior. Sometime they are very specific while at other times the unique qualities of the situation we find ourselves in are not clearly described in the Guide, so we need to interpret the Guidelines in order to make our decision.

The ACA Code of Ethics is organized into the following sections:

- Section A - The Counseling Relationship
- Section B - Confidentiality and Privacy
- Section C - Professional Responsibility
- Section D - Relationships with Other Professionals
- Section E - Evaluation, Assessment, and Interpretation
- Section F - Supervision, Training, and Teaching

- Section G - Research and Publication
- Section H - Distance, Counseling, Technology, and Social Media
- Section I - Resolving Ethical Issues

As you can see, the Code is fairly comprehensive. Because of the way it is organized (into small sub-sections of different ethical guidelines) it is actually a fairly easy read. Take some time to review the entire document and identify guidelines that you think are relevant to the career path your are going into.

MHRT/C Code of Conduct

In addition to the American Counseling Association's Code of Ethics, you will want to familiarize yourself with the "Code of Conduct" developed in the State of Maine specifically for MHRT/Cs.

Download the MHRT/C Code of Conduct

This is the first rendition of a specific Code for MHRT/Cs and reflects some of the areas that have been a problem since the inception of this certification. Clearly you can see that the core values of the Psychosocial Rehabilitation model are outlined in the Preamble.

In addition, you can review the kinds of issues and problems that have been identified over the years. The first 4 standards have to do with sexual, romantic, and other dual relationships with clients!

In order to maintain their MHRT/C certificate, individuals are going to need to sign off that they understand and will comply with these ethical guidelines.

Where People Are

One of the key aspects of Psychosocial Rehabilitation perspective in any application of mental health practice is the notion of "meeting people where they are at."

This phrase has a more geographical history than it does today. The basic expectation of the Independent Living Movement is that services for persons with disability should go OUT into the community and encounter clients in their own environments. So, the phrase, "meet people where they are at" had a literal interpretation.

While this viewpoint is still relevant today (community based mental health is usually delivered in clients' homes and other environments), the meaning has been expanded.

The ethic of meeting people where they are applies to understanding and accepting where a person is at in terms of their

path to recovery, their commitment to change, their personal values and interests, along with their physical space. The place they are is the starting point of your work with them.

Often we would like to have our clients be different. We would like them to be motivated, excited about change, and to share our values in terms of work ethic, the desire to improve themselves, and motivation. These are strong and common characteristics of many people who work in the mental health field, but these values are not necessarily shared by your clients!

Multicultural Perspective

When we hear about “multiculturalism” we often think of ethnic and racial diversity...I know I think of FOOD!

However, cultural diversity is not defined solely by race and ethnicity. Each of us grew up in a slightly unique culture of our own called “our family”. This group, for better or worse, taught us values, expectations, norms of behavior, ambition, and what is right and wrong.

From that point, as adults, we have modified some of these aspects of our own culture and created some of our own. So, when we meet anyone, even if they are of the same race and/or ethnicity that we are...we are having a multicultural experience.

Culture

According to the definition put forth in Wikipedia, “Culture is the social behavior and norms found in human societies. Culture is a central concept in anthropology, encompassing the range of phenomena that are transmitted through social learning in human societies.”

As you can see, culture is pretty all-encompassing. It really refers to all the aspects of of social situations and society and how it impacts our behavior.

Perspective

As we grow up we are “socialized” (taught from generation to generation) about how the “world works.” Throughout our lives we have a tendency to favor our own world view...this is called “ethnocentrism”. While this term may be used in a negative way, it is something we all possess. Most of us are more comfortable when we are surrounded by familiar things and behavior. When we are surrounded by behavior that is very different than our own, we may become uncomfortable, scared, angry, or simply freeze.

Yes, there are some people that seem to thrive in these types of circumstances, but that is more a function of the persons’ personality. Personality theory identifies “openness to experience” as a measurable trait. Persons who have a high degree of this trait are still “ethnocentric” but they may be more than willing to go with the flow when things are different because they are “open to the experience”!

Our Client’s Perspective

What is deemed normal behavior and expectations for our clients may not be in line with our experience. In fact, it often is not. So, we are always in a multicultural experience with our clients and we are always experiencing a degree of ethnocentrism when our clients’ values and norms do not agree with our own.

For example: Let’s say that you have a client who grew up in a home and adopted the norm that smoking pot with the kids was OK. You might be horrified by the thought of a parent giving drugs to their kids. What you are experiencing is a state of discomfort because your client’s values do not match yours and you feel that your’s are probably more functional or better.

Regardless of the fact that it may actually be better if the parents did not provide drugs to their kids, it is still a function of ethnocentrism.

So, what is the point?

The point is that in order to fulfill the basic premise of this kind of work encapsulated in the phrases “unconditional positive regard” and “meeting our clients where they are at” we need to see our ethnocentrism as a barrier between us and our clients!

Let that sink in! Our ethnocentrism is a BARRIER in our client’s lives. Here is what we need to do:

- Be very aware of your own biases and values and how they may be different from your clients (and even your co-workers.)
- Nurture a respect for the fact that all of us have built these perspectives from a time in our development where we were not necessarily making CHOICES. All of is, including you, have been indoctrinated (to a degree) by our families,

schooling, economics, etc. to see the world in a particular way. So, we are not fully responsible for the fact we are who we are...part of it is because we were raised that way.

- Take responsibility to suppress your own judgement of others based on these differences.
- Nurture a respect and understanding that the world view of others has worked for them (for the most part) for quite some time and they are not always eager to change this world view, even if it will result in some positive outcomes.
- Talk openly about the different values and norms that you have with your client without judging one as right or wrong. You can, however, point out how specific aspects of a person's culture may be at odds with goals they have. A person with lots of tattoos covering their body may hold a world view of the beauty of inking the skin, but this may be at odds with other cultural viewpoints and stereotypes.

Human Development

Another aspect of individual diversity has to do with development. You see, we are continually changing through a process of both maturation (biological and genetic aging) and through learning (environmental factors and changes that we adapt to).

Part of "meeting your client where they are at" has to do with their stage in development. While a full treatment of Developmental Psychology is best presented in the course by that name, we can cover some of the basic models and how they can help us understand where someone is at.

Cognitive Development

The ability for someone to understand language, abstract concepts, and consequences of actions is based upon them having reached specific cognitive developmental milestones.

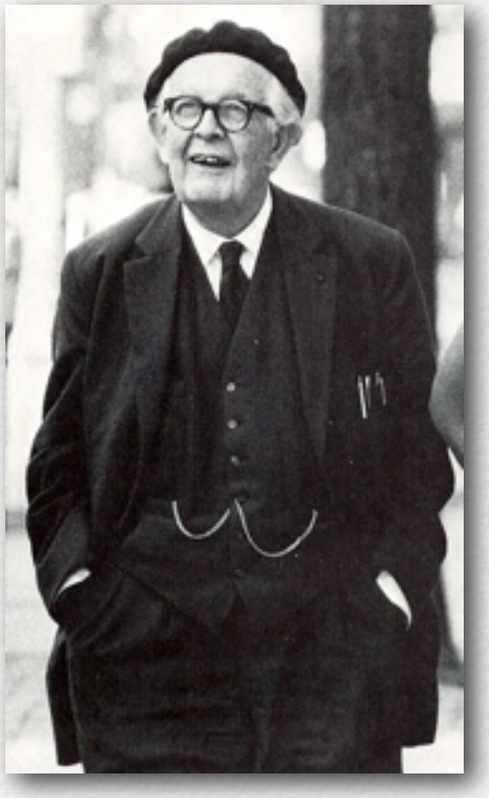
Below you will find a link to a great article that covers many of the perspectives on cognitive development in adults. Here is the reference to the source material that made up this article.

Schaie, K. W. (2008). A lifespan developmental perspective of psychological aging. In K. Laidlaw & B. G. Knight (Eds.), The Handbook of emotional disorders in late life: Assessment and treatment (pp. 3-32). Oxford, UK: Oxford University Press.

Click HERE to view the article.

Piaget's Theory of Cognition

One of the most prominent theories of cognitive development was put forth by Jean Piaget (1896-1980).



Piaget's theory, known as **Genetic Epistimology** (a term that refers to the "genesis of ways of knowing" not to "genetics" as we understand it today), proposes that people develop through distinct stages of cognitive development as a result of their active engagement with the environment in which they are living.

The basic developmental process involves two actions: Assimilation and Accommodation.

Assimilation is the action of incorporating new ideas into our knowledge of the world. Piaget refers to these "ideas" or "concepts" as **schemas**. Each of us has assimilated many schemas into a mass of information that allows us to understand the world.

Example: We may encounter a horse very early in life and when we look at our caregivers inquisitively they tell us it is a horse. We then assimilate the totality of this experience into a relatively basic understanding of "horse" with the word, the animal, and the surroundings we see the animal in being incorporated into the new schema.

The next process is **Accommodation**. Accommodation is the action whereby we are forced to modify or change an existing schema based on new information. This refers to the "old dogs new tricks" notion that ideas we have had for many many years are relatively resistant to accommodation!

Example: You now have a schema of horse, a very basic one. Later that day on the same farm you encounter your first cow. You may immediately generalize what you know about horses and call the cow a "horse"! Your caregiver gently tells you that this is not a horse but a cow. You simultaneously begin to construct a NEW schema for "cow" and assimilate that into your

cognitive world, while you accommodate your already established schema of horse to exclude all cows!

This image might represent some sort of transitional state of different schemas!

Piaget's Stages

Piaget's stages reflect cognitive changes from early infancy on.

Sensory-Motor Stage

- Birth and very early childhood
- Characterized by an eager exploration of the world and the integration of motor movements and sensory experiences.
- Piaget identified three sub-stages:
  - Primary Circular Reactions - the child randomly creates a sensory stimulation (such as making the mobile move as they are waving their arms around) and attempts to repeat it (this is the "circular" part...the attempt to repeat it.)
  - Secondary Circular Reactions - having come to an understanding as to the physical properties of objects, they seek out these objects to elicit these sensory stimulations (a child learns that a rattle makes noise so they seek out the rattle and immediately begin shaking it.)
  - Tertiary Circular Reactions - in this stage, the child begins to "wonder" of the physical properties of one object are the same as other objects. For example, a child may have learned that "balls bounce"...and, to our horror, they try to find out if "cats bounce" as well!

Pre-operational Stage

- Toddlerhood
- In Piaget's model, "operations" are synonymous with "schemas". This stage is primarily focused on the development of the most basic schemas related to objects, the physical world, perspective, and time/space.
- Children are learning to associate words with objects in the development of object oriented schemas.

- Typical errors that a child will make as they develop schemas for the physical world, perspective, and time/space can be understood with these examples:
    - The pre-operational child will think that putting on a costume actually transforms the person. Halloween can be really scary!
    - The pre-operational child, while talking to their grandmother on the phone, can look down at their own shoes and say “Look at my new shoes, Grammy” and feels that Grammy can see what they see.
    - The world of make-believe is very magical and real to the pre-operational child.

<u>Concrete Operational Stage</u>

- This stage is characterized by the development of complex language, complex schemas, and a sense of the limits of the physical world, perspective, and time/space.
- Schemas are distinct from the next stage as they are based in the “real world” or they are “concrete”.
- Perspective is dominated by personal experience, though some allowance for alternative perspectives can develop.
- The typical “errors” associated with pre-operational thinking disappear.
- Self perception is made up of complex, but mainly concrete descriptors.
- It is important to state here that, according to Piaget, most people do not necessarily progress (nor need to progress) beyond this point. Most of our activities in our adult lives are based upon Concrete Operational processes.

<u>Formal Operational Stage</u>

- Formal operations develop as a result of specific environmental factors interacting with specific maturational factors.
- Formal operations are schemas that can be based upon abstract principles. These abstractions can be applied to the social world, scientific inquiry, perceptions of self and others, and to the world of ideas.
- Formal operational thinking can develop in adolescence and continues to mature through adulthood.
- Formal operational thinking is a necessary component of abstract reasoning (such as Algebra!), deductive and inductive problem solving, advanced problem solving, advanced moral perspective, and consequence (this one is particularly important.)

Issues that may arise due to Piaget's Stages

Since most of our work is with adults, we can focus our attention on the Concrete and Formal Operations stages of this model. We have already stated that, according to Piaget, most people do not advance beyond the Concrete Operational Stage. This is NOT a form of developmental delay, but it IS an explanation for the absence or difficulty some of our clients may have with the world.

In the absence of formal operations our client may:

- Fail to see the potential consequences of actions today on tomorrow.
- Struggle with treatment planning that sets goals far into the future.
- Struggle with delayed gratification.
- Fail to take into consideration multiple perspectives on any situation they may be involved in.
- Fail to understand that others do not necessarily know that they have a mental illness and may be surprised by their behavior.
- Lack an understanding of others' experiences.
- They may literally possess "concrete", "all or none" or "black and white" cognitive habits.
- Coupled with trauma, the client may not be able to see the world outside of the impacts of Trauma.

Understanding these aspects of our clients' cognitive framework should inform our practice.

- We can understand some aspects of resistance as being connected to cognitive style.
- We need to tie concrete motivational factors to treatment planning.
- Treatment planning can focus on long term goals, but cannot neglect short-term rewards/goals along the way.

Piaget's theory has been applied to the development of Moral Cognition through Kohlberg's Theory. This is an expansion on Piaget's model so it may be sufficient to check out this video below on Lawrence Kohlberg's Theory of Moral Development.

Schaie and Willis Theory of Cognition

Klause Warner Schaie

While Piaget's stages well define the process of changing ways of acquiring and processing new information and experiences, the Schaie and Willis theory focus on how adults change in respect to WHY and HOW they use information and experiences. There is a practical and applied sense to adult cognition.

Note: This is why the term "Pedagogy" is REALLY the study of the teaching of Children, and "Andragogy" is the study of teaching Adults. Adult learners, largely those at the college level and above, often need to have an understanding of the utility (or usefulness) of the material they are being taught. While they may enjoy learning things for the sake of learning them, there is a practical side to going to school...basically, many adults in college ask "How is this going to help me in my future job."

Sometimes, it is hard to directly answer that question!

Young Adults - Achieving Stage

- Primarily focused on the use of knowledge to acquire careers and to raise families.
- Monitoring own behavior.
- Personal independence.

Young Adult to Middle Age - Responsible Stage

- Focus on social responsibility.
- More awareness of place in the social hierarchy (at home and at work).
- Transition to focus on others as well as self and family.

Middle Adulthood - Executive Stage

- This stage development depends largely on exposure to opportunities to impact social change (home, work, society, etc.)

Middle Adulthood - Late Adulthood - Reintegration Stage

- Solidification of values and perspectives on the world.
- Desire to pass on to the next generation (closely tied to Erikson's Generativity Stage).

- Less likely to “waste time” on tasks they view as meaningless.
- Selective reduction of personal networks...in a way, they decide who matters (see Looking Glass Self)

Late Adulthood - Reorganizational Stage

- Legacy building and tying the threads of a consistent self together (closely tied to Erikson’s Integration Stage).
- Restructuring of personal life to reflect stage (work may be absent, new roles in the family, new opportunities in the community, etc.)

Issues that may arise due to Schaie’s Stages

Consider that these stages are a result of both the developing and maturing person, and social expectations. At specific ages, society has come to expect that people will be in these specific stages.

This may impact our clients in a couple of ways:

- Our clients may want to engage in these stages but lack the world experience and opportunity to do so. If a person, for instance, has not had a regular work history they may find the transition into Middle and Late adulthood to be challenging because they cannot engage in reintegration.
- Society may heap upon our clients an additional level of stigma associated with age. Disability early in life and often delay development. Some of our clients may enter into these stages later in life and their goals may be out of sync with the “Social Clock” or the time frame that our societal expectations deems for these stages. For instance, a client in Middle Adulthood may be getting their first job and learning to use their cognition to learn that job, while being supervised by someone significantly younger than they are.

Our interventions need to bring these stages to the attention of our clients. We would do well to identify aspects of our clients lives where they can enact these stages outside of work and family (if work and family do not exist, or have not been well developed in the person’s life.)

Social and Identity Development

The human experiences is not confined to the world of cognition. Humans think and act in a context, their social world. The “forces” of cognitive maturation and social interactions interact to formulate a persons’ sense of themselves, identity, self-concept, and social roles.

The following are some models that focus on these areas of change.

Theory of Mind

Theory of Mind is a critical development in a child's ability to organize their social world. Essentially, it can be described as the awareness that others have thoughts unique to our own and that others act on what they believe to be true. Theory of Mind (ToM) is a critical precursor to "perspective taking" which is, in kind, a necessary aspect of moral thinking and behavior. We need to understand that others may think differently than we do before we can "walk a mile in their shoes."

We know that ToM usually manifests in a child at around age 3. But there is a definitive test. ToM is almost certainly present when a child begins to lie!

Consider this story...

Betty (age 3) and her mom are in a store. Betty is "flying" around like an airplane avoiding imaginary clouds and other imaginary airplanes. She runs into a stack of boxes and they all come tumbling down.

Betty's mom rushes to her side and asks what happened. Betty thinks about this for a moment and says "Roger (the imaginary other pilot) flew his plane into the boxes!"

From this story we can be pretty sure that Betty has ToM. We know this by considering her motives for lying. Betty is aware that she is the one that knocked down the boxes, she is also aware, perhaps mistakingly, that her mom's rush to her side, may indicate that mom is angry and may punish Betty for knocking down the boxes.

In order to avoid punishment, Betty places the blame on her imaginary wingman. Although we may think that Betty's desire to avoid punishment is evidence of pretty advanced thinking, it is actually the nature of the lie that is impressive.

Betty, who likely has ToM, knows that if she can convince her mom that Roger actually knocked down the boxes, her mom will act on what her mom THINKS happened, not based on the truth (which Betty alone is aware of.) Betty is trying to manipulate her mother's understanding of the situation, knowing mom will act on her beliefs of what happened, instead of the truth.

While lying children may worry some parents, the appearance of this kind of lying is cause for celebration. Betty is on her way to developing the key components of moral thinking, perspective taking, and altruistic behavior.

Issues that may arise related to Theory of Mind

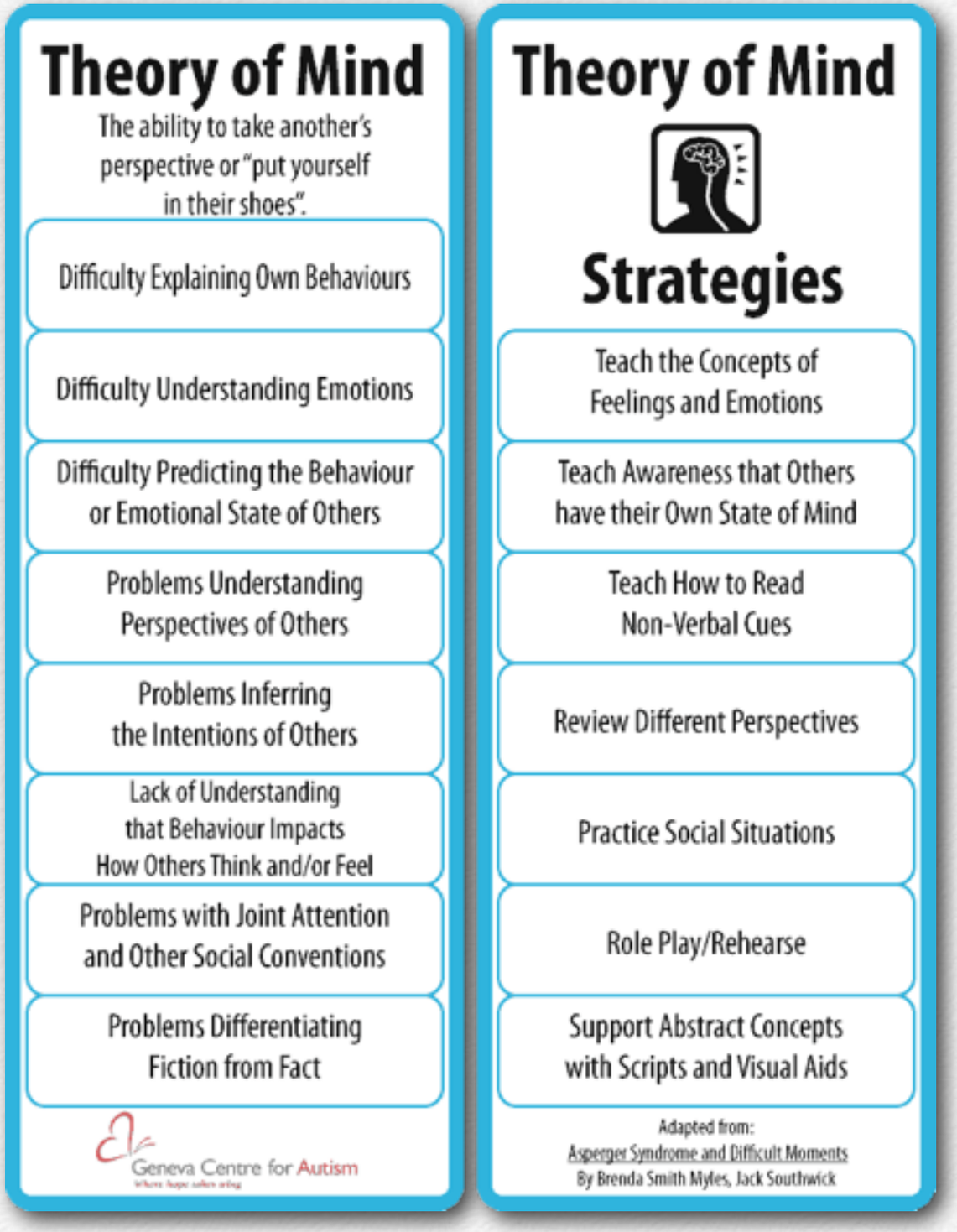
Theory of Mind is largely thought of as an aspect of maturation, meaning it is largely controlled by biological and genetic factors. Even individuals with a traumatic past, may still successfully develop ToM.

ToM is one of the key components of human cognition that may be deeply impacted in Autism Spectrum Disorders.

Click HERE to read an interesting, though dated, article about the link between Autism and Theory of Mind.

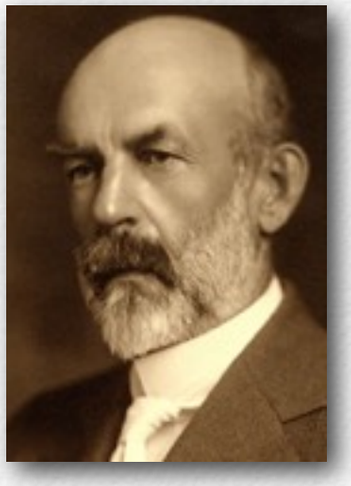
This may impact our clients in a couple of ways:

- Our clients may not understand the impact their behavior has on others and may appear overly selfish and self-centered.
- The goals of others may be secondary to personal goals.
- Social awareness (cues in facial features, expressions, and even certain types of language) may be restricted.
- We need to understand that these are cognitive-behavioral aspects of the person, not necessarily willful.
- Keeping with the philosophy of meeting our clients “where they are”, we would venture to look at linking behavior to more immediate consequences (Behavior Management) such as rewards and punishments.



Looking Glass Self

Charles H. Cooley was an American Sociologist who developed the concept of Looking Glass Self to forward the concept that a person's "self" grows out of a society's interpersonal interactions and perceptions of others.



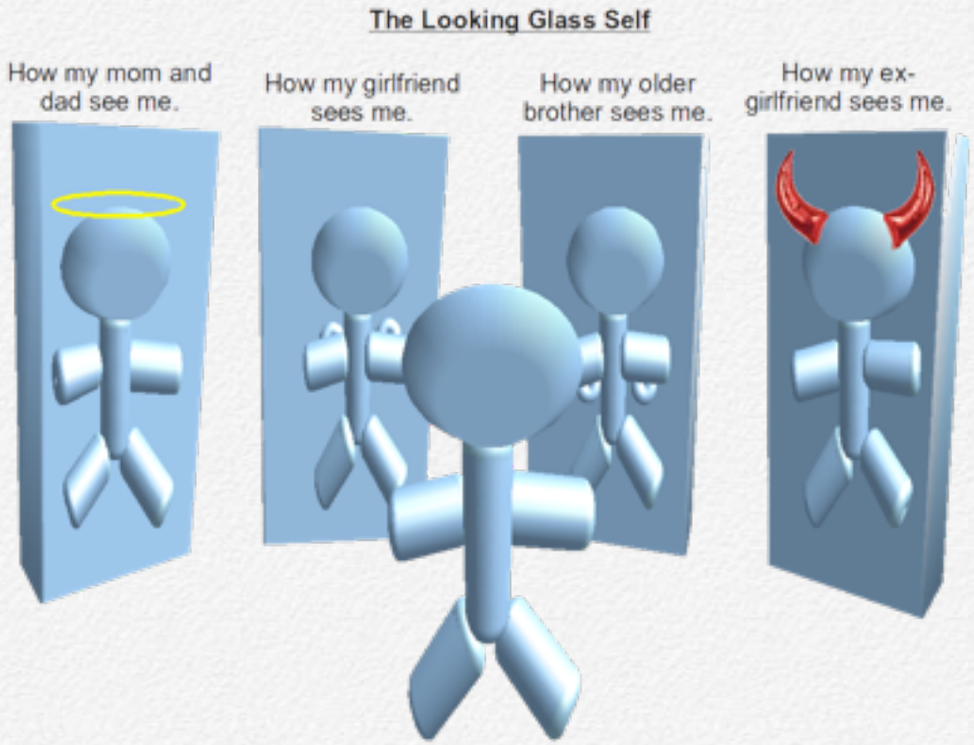
Charles H. Cooley

Understanding Looking Glass Self

Looking Glass Self describes the social nature of the development of a sense of self (self-concept, self-efficacy, and self-esteem.) Here is how it works:

1. We look at ourselves (as in a mirror) and see all of our qualities. Our looks, intelligence, skills, faults, etc.
2. We then imagine how others may see these qualities in us. Based on our understanding of how others think (Theory of Mind) we imagine how they might "judge" our qualities (even those that may be unknown to others.)
3. Based on these assumptions as to how others see us, we formulate a sense of self. If we assume that others see us as "ugly" or "bad" we can develop a self-concept that we are "ugly" or "bad"

This video from Khan Academy does a pretty good job of explaining Looking Glass Self



It is very important to remember that we often SELECT the people who we "use" in this way. In this image we see that "important people are impacting the self-image of this person... mom and dad, girlfriend, older brother, and ex-girlfriend.

Issues that may arise related to Looking Glass Self

We all develop parts of our sense of self from the important people around us. Even as we mature, we recognize that certain individuals (our parents, co-workers, supervisors, etc.) continue to have an influence on how we feel about ourselves. Over time this may become less impacted by others' thoughts of us (we will discuss this in Erikson's theory next) but throughout our lives we apply this concept to formulate part of our sense of self.

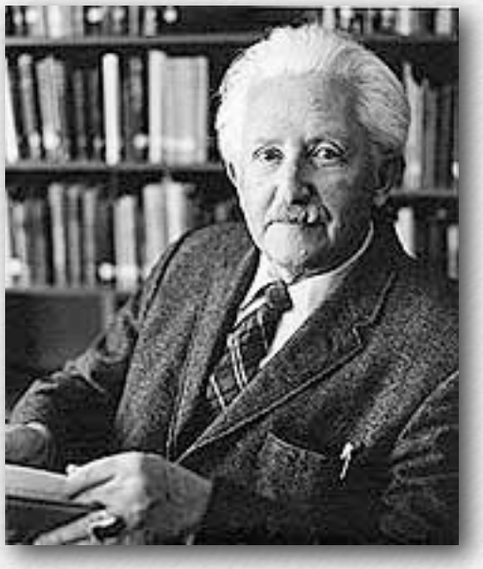
- Some people, with or without any specific mental illness, may include a LOT of people in this set of influential others. They might include society as a whole. People who might be very concerned about what "THEY" think, without being able to clearly define who THEY are, are in this category.
- Negative early childhood experiences with critical others (family, teachers, religious leaders, etc.) can create a lasting and persistent negative self-image. For example: "My first-grade teacher told me I would amount to nothing." As foolish as this assessment seems, when it comes across an impressionable young mind, it can have lasting negative consequences.
- This one is a bit complicated. A young man's reputation as a "stud" may enhance others' perceptions of him and inflate his sense of self based on Looking Glass Self. On the other hand, a young woman's equal reputation could have a negative impact on others' view of her.
- Related to that last one, young women may come to perceive that their male counterparts would like them better if they were sexually active. They assume that the partner

perceives sex as an act of “commitment and intimacy” as they do. Some may be devastated by the fact that their male counterparts do not feel any more intimate nor committed to her once they have had sex.

- Positive role models can have a tremendous impact on others’ self-concept. As mental health workers there is an aspect of our work that attempts to place ourselves and the treatment plan into this mirror. Success in a treatment plan can lead to positive changes in self-image.

Erikson’s Psychosocial Theory

Erikson is one of the most famous psychologists to have ever lived and his theories have had lasting influence on the field of Psychology.



Erikson was a German-born American Developmental Psychologist and an early follower of Sigmund Freud. Freud had developed a theory of human development based upon the instinct of procreation of the species and sexuality. Freud titled his model Psychosexual Development. Erikson felt that the social interactions that children (and adults) have are more important. So, he broke ranks with Freud and developed his, now famous, Psychosocial Theory.

True to his early years as a tall, blond, German musician traveling around Europe in search of himself, Erikson’s model is, at its heart, an Identify Development theory.

Erikson’s theory proposes that as we mature we encounter fundamental challenges between our emerging selves (personality and cognition) and the social world around us. These challenges are portrayed as 8 fundamental crises.

Crisis #1 - Trust vs. Mistrust

During the first year of life the infant needs to develop an expectation that the world will meet their needs and that they are welcomed and loved in the world.

Crisis #2 - Autonomy vs. Shame and Doubt

Somewhat aligned with the “Terrible Twos”, this stage has the child experimenting with acting independently in the world. The child is trying to do things for themselves. The degree to which

the environment encourages and supports this safe exploration of autonomy is the degree to which the child can successfully navigate this stage.

Crisis #3 - Initiative vs. Guilt

Covering the approximate ages of 3-5, this stage is characterized by the child's imagination and idea generation. Through play and interaction with others, children learn to make decisions, lead, and come up with new ideas.

Crisis #4 - Industry vs. Inferiority

Encompassing the ages of 5-12 (early school experiences), the focus of this stage is the development of competencies and skills (industry) and comparison with others' who are also developing these same skills. The before-mentioned Looking Glass Self becomes a larger part of their lives as school assessments, teacher's grades, and peers begin to have an influence on their sense of self.

Crisis #5 - Identity vs. Identity Diffusion

Occurring during what we would call "Adolescence", this is a focal point that connects the four previous crises into a cohesive (though incomplete) sense of identity that is ready to enter adulthood. For many this is an intense period of exploration of personal values, beliefs, and goals independent of those set by family and others.

Crisis #6 - Intimacy vs. Isolation

With a largely developed sense of self and personality, the person may be ready to develop close relationships with others on an adult level. In a way, this stage is the purposeful addition of individuals to your Looking Glass Self models. Intimacy can be seen as the selection of someone whom you trust enough to assist you in the development and evaluation of your self through the Looking Glass process. That can be a pretty big deal!

Crisis #7 - Generativity v.s Stagnation

This is by far the longest lasting of all the stages. This is the stage where we create our life's legacy. We build a career, we have hobbies, we create family, etc. We fulfill our purpose on Earth largely during this stage.

Crisis #8 - Integrity vs. Despair

As we approach the end of life and our opportunities diminish, we attempt to weave together a unified tapestry of who we are and who we have been. To encounter the results of bad decisions and selfishness at this age can lead to a deep despair as we realize there is sometimes nothing we can now do to change it.

As you can see, this is a very comprehensive theory that explores major milestones in our lives!

Application of Erikson's Theory

"Failure" in a Stage

The first application is to consider what happens if someone does not do well in a stage. What happens if someone lives in an environment when they are three years old that does not encourage initiative?

First, according to the model, a failure in one stage makes it more likely that a failure could occur in the next stage.

Second, all is never lost! We can return to these stages, in a way, and rebuild out experiences.

We know, however, that early childhood experiences (Stages 1-4) can have a lasting impact on a person.

Continual Cycles of Development

I'm not quite sure how else to say this! Whenever we encounter a new aspect of our lives...we enter a relationship, we get a new job, we move to a new place...we enter in a micro-version of this model. Consider the stages of a new relationship:

1. Trust vs. Mistrust - Do we get to understand that the person is reliable and can meet our needs?
2. Autonomy vs. Shame and Doubt - Can we continue to be ourselves (in some ways, the one we were before the relationship) and still remain in the relationship?
3. Initiative vs. Guilt - Can we introduce changes into the relationship, take charge and command leadership (at least on some things)?
4. Industry vs. Inferiority - Does the relationship "work", are we "good at it" and we have worked out ways to cooperate to deal with the day-to-day challenges?
5. Identify vs. Identity Diffusion - This could be a fundamental stage where we decide to make the relationship permanent. Are we ready for the shared sense of self that comes with intimacy.
6. Intimacy vs. Isolation - Can we survive the initial years of committed relationships. Commitment means that we open ourselves to risk. Intimacy literally means to know things about the other. As some aspects of our real selves begin to show, will the relationship survive it?
7. Generativity vs. Stagnation - What is the legacy of the relationship? A house? Kids? Retirement? This is the long-term work of the relationship. This is also the stage in which some challenges (such as mid life) can cause us to question lost opportunities.

8. Integrity vs. Despair - In terms of later years in the relationship this is all about tying together the two individuals into a single sense of unified self. It is not uncommon to find that elderly couples, who have been with each other for decades, are intimately "connected at the hip" and sometimes may seem to be "overly" dependent on one another (from the viewpoint of our younger personal stages.)

You can apply each of these stages to what someone may go through as they are making personal changes. Different than the Stages of Change theory, this describes the components and challenges of long term change.

Challenges that may arise in these Stages

All of the theories discussed in this section can be referred to as "normative". This means that, unless something comes along (like a chronic illness) these stages happen to most people.

In addition, there seems to be an innate sense of the necessity of these stages that has been taught to nearly everyone. People generally have a sense that we move from a relatively dependent part of our lives to increasing independence, that a sense of identity based on relationships and work is expected, that relationships and family are shared goals, that we nearly all have a sense of wanting to do something important with our lives, and that we all face a time at the end of our lives where we encounter the facts of our time on Earth.

For persons with chronic disease these stages can sometimes be poorly addressed. This means that although the person may feel, for instance, that they are at the stage in their lives where intimacy "should" happen, they may struggle in a lot of ways due to the fact that previous stages have been poorly addressed.

1. They may lack a sense of identity that would help them in finding a good partner.

2. They may lack the social skills developed in Stage 4 to negotiate social relationships.

3. Their identity may be poorly defined and their sense of self may be overly dependent on the opinions of others and their status (in a relationship vs. not)

4. Basic trust issues unresolved very early in life make it challenging to really believe that someone will meet their needs.

5. A poor sense of autonomy can create an overly dependent individual who may be taken advantage of.

Development and Mental Illness

This Chapter attempts to recognize that developmental changes represent the canvas unto which we are helping our clients paint their lives.

It is important to understand the innate changes and expectations and the societal values of behavior related to age that our clients encounter.

Studying more details in each of these theories is highly recommended. Understanding the natural maturation and developmental process of people is a great asset that we can use to facilitate change in our client's lives.

Assessment

Chapter 2 Discussion A

In this discussion I would like you to reflect on the different developmental theories that were presented in this Chapter. Describe current or past situations that you have been involved in that exemplify the importance of taking these models into consideration when solving a problem.

You CAN imagine a specific problem happening in your life during a particular age, and then discuss how knowledge of these models would modify your approach or practice.

Chapter 2 Discussion B

In this discussion we are going to review the MHRT/C Code of Conduct. Express how you feel about some of the specific guidelines and why they appear in the list.

Are there any of these that you might find difficult to follow at times?

Motivational Interviewing and Treatment Planning

3

Attention

The Process

While this graphic outline the steps in Treatment Planning that align very nicely with the steps in Motivational Interviewing.

We will be merging these two models to develop a set of expectations for your practice in this course and beyond.

Learning Outcomes

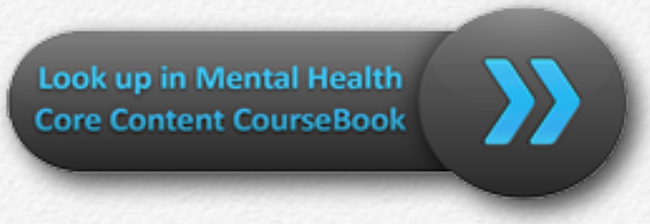
Upon completion of this Chapter, students will be able to:

1. Identify how each of the steps in MI can contribute to the development of S.M.A.R.T. goals and the treatment planning process.
2. Provide personal examples of goal setting using the S.M.A.R.T. terminology associated with goal setting.
3. Write a treatment plan based upon an established format and integrate S.M.A.R.T. goals into the plan.

Teaching

Motivational Interviewing

The Motivational Interviewing process is also outlined in the Mental Health Core Content CourseBook.



Text Link

Review p. 8 in the CCNC Motivational Interviewing (MI) Resource Guide.

The basic steps in the MI process are as follows:

- Engaging - Empathic Listening
- Focusing - Targeting Change
- Evoking - Client's Ideas
- Planning - Getting to Change

Each of these will be covered in detail later in the course but I think it is important to see how these skills integrate into the Treatment Planning process that you will be engaged in all the time.

Treatment Planning Process

The Treatment Planning Process is also outlined in the Mental Health Core Content CourseBook.

Text Link

When you meet a client for the first time you often have a sense of what might be going on based on the referral information. However, despite the fact that you may already have a good sense of what you are going to do, it is vital that you go through each step of the process in order to be most effective

The basic steps in the Treatment Planning process are as follows:

Build the Relationship - Establish rapport through questions and conversation.

Identify Problems / Assessment - Establish a good sense as to how the client sees the problem or problems.

Get the Story - You want to get as much background on the problem as you can, including the history of the problem and previous efforts to solve the problem. This is also where we can identify strengths and resources that the person has.

Identify Barriers - Barriers are the circumstances that are in the way of "fixing" the problem, or accomplishing the goal. Some barriers are exterior to the person (money, transportation, perception of people with mental illness) while others are internal to the person (personal motivation, lack of skills, behavioral challenges).

Goals - Goals focus the individual on the picture of where they want to be...what do they want life to look like once they have accomplished the goal? Complex, multi-step goals can be divided into sub-goals or steps.

Planning - Our plans, in nearly every regard, focus on linking our clients to the services they need to solve the problem or accomplish the goal. These should be based in reality, should identify the person or persons responsible for the goal, and should provide a time frame for periodic review and accomplishment.

Review - The overall plan of someone should be reviewed, re-assessed, and re-written on a regular basis. Our world changes, so do our goals.

This is actually a CIRCULAR process best represented by the figure in the Attention section of this Lesson Plan!

Can you see how there is tremendous overlap between these two models. We will be engaged in BOTH of these models through the course.

Writing Goals

When we help our clients write out goals (or when we set our own goals), we want to be sure that they are clear. We are going to put some work into accomplishing these goals so it is important that everyone involved is on the same page.

Goal Statement Construction

As you set out to write a goal you want to think clearly about what is to be accomplished, when it is going to be accomplished, who is going to do it.

Complex goals should be broken down into each part so that each part has its own goal (what will be accomplished, when, and by who.)

There are a couple tools we can use in the construction of Goal Statements. We will discuss them here. The first tool consists of making sure that each Goal Statement meets are written to meet the S.M.A.R.T. guidelines. The second tool consists of two “tests” that you can use to ensure that your Goal Statements are “specific” and “measurable”.

S.M.A.R.T. Goals

Click HERE to visit a website that explains how to write S.M.A.R.T. goals and provides numerous examples.

S.M.A.R.T. Goals

As you work through this class the goals that you write will be evaluated using the S.M.A.R.T. formula.

Keep in mind that the S.M.A.R.T. process is used to internally think about and evaluate the goal that you have set. When you write out a goal, read it to yourself and ask the 5 questions outlined by this process:

1. Is the goal specific?
2. Is the goal measurable? (Will it be obvious when the goal has been completed and is it written in a way that ANYONE can understand it?)
3. Is the goal attainable? Is it actually possible to make this happen?

4. Is the goal relevant to the overall independence of the person?

5. Is the goal timely? Can it be done in the time frame that we have set (this is also part of the "attainable" evaluation) and is NOW the time to do this (with all the other things that can be going on.)?

If your goal statement passes all of these questions...it is probably a good goal statement

Stranger Test and Dead Man's Test

This particular tool (the two tests) provides you with a way to ensure that your Goal Statement is both precise and measurable.

Stranger Test

For the Stranger Test you have to read your Goal Statement and ask yourself: "Could a stranger off the street read this goal statement and understand what the goal is?"

While this might seem silly, we have a tendency to write a lot of goals that assume some background knowledge a stranger would not have.

Let's say you write a goal as follows:

"Mark will exercise 3x per week"

If you were working with Mark on this goal, this might make sense to the both of you based on what you know for background information, but, if a STRANGER had to read this, what does "exercise" mean? Walking, swimming, 1 hour, 10 minutes?

As you can see, this goal is not specific enough to be clear as to what the goal is. You would need to change the goal to something more specific, such as:

"Mark will go to the YMCA three different days a week and swim at least 20 laps in the pool."

Dead Man's Test

This test is a bit more complicated to understand. As with the stranger test, you have to read your Goal Statement and ask yourself a question: "Can a dead man do this?"

What this test reveals is when you have created a goal that cannot be measured. Although this is a bit silly, consider the following goals:

"Tom will sit quietly in class."

"Bethany will not tease her younger sister"

"Brook will sit in the library and study 3x per week"

If you really think about it, a Dead Man can actually do these things! A Dead Man can sit quietly in a room, can NOT tease someone, and, really, what does "studying" look like?

In order to change these goals you will need to become more specific and measurable:

"Tom will complete three graded worksheets"

"When tempted to tease her younger sister, Bethany will instead go to her room and write in her journal."

"Brook will spend 2 hours in the library and complete three chapter summaries and outlines."

You can NOW see that a Dead Man cannot do these things!

So, if your Goal Statement passes both tests (A Stranger CAN understand the goal and Dead Man CANNOT accomplish the goal) then your Goal Statement is probably all right!

Nothing better than examples...

Example 1 - Writing Goal Statements

Let's say that you (Samantha) want to set a goal to get in better physical condition. That is an excellent goal, but it is also a complex goal. So, we might have to break that down into some different parts.

These "parts" get discussed with your client when you are engaged in the "Evoking" stage of the MI process.

So, the goal is broken down into three parts: one involves going for walks on a regular basis, another has to do with always taking the stairs when going home to your apartment, and a third has to do with getting information about having a YMCA membership. In this particular case, the Case Manager will be the one responsible to get the information from the YMCA.

Goal 1: Samantha will walk around her housing unit twice every morning (7 days per week) starting on February 10, 2018.

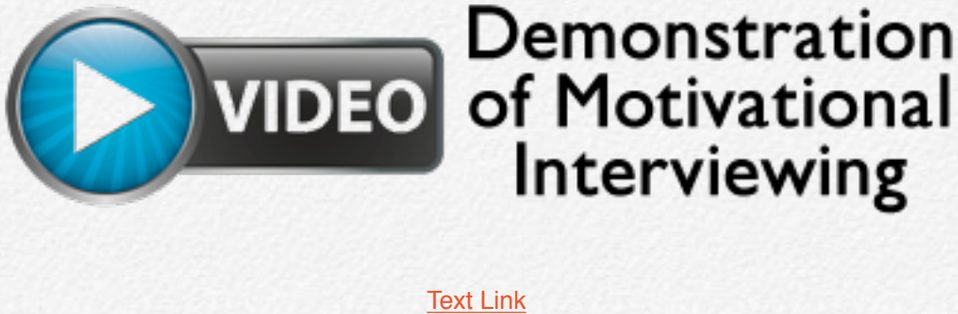
Goal 2: Each time Samantha has to go to an upstairs floor (at her apartment and at her work) she will elect to take the stairs at least 50% of the time starting on February 10, 2018

Goal 3: Case Manager will obtain membership information from the Augusta YMCA and review it with Samantha on February 17, 2018

Example 2 - Writing a Treatment Plan after a Session

Below you will find a link to a video demonstrating a single session between a counselor (Dr. Kavanaugh) and a client (Dr. St. Pierre) utilizing the Motivational Interviewing model.

In the video you will encounter text that identify when Dr. Kavanaugh is engaged in a specific step or stage of the process.



Text Link

Following this session, Dr. Kavanaugh produced the following Treatment Plan. This plan is formatted in the same manner in which you will be expected to submit all treatment plans in this class.

Click here to download the Treatment Plan that goes along with this demonstration of Motivational Interviewing.

When you are asked to write your treatment plans in this class you will set your sights on this example.

Assessment

Chapter 3 Discussion

In this discussion I would like each of you to post an example of a goal that you have personally accomplished in your life. Describe the goal attainment using the same terminology that is used in this Lesson Plan.

To tell the story of your goal attainment you are going to use your iPad and an app called Adobe Spark Video to create a visual story! Your story will include text, graphics and pictures, along with your voice telling us the story. Check out the iPad Integration box below for more information.

Your story must explicitly identify each of the S.M.A.R.T. components. In fact, in the text component of the presentation, we should see each of these terms appear when you are talking about them.

Text Link

Use the link below to access the tutorial on how to use this app in the iOS and App Tutorial CourseBook.

Text Link

Chapter 3 Assignment

MI in Treatment Planning

This assignment consists of two parts. When you write this up it will be submitted as ONE document with a title page and both parts, one after the other.

Part I: Write a 1-page essay expressing your understanding of the interrelation between the Motivational Interviewing steps and the Treatment Planning steps.

Part II: Based on the template and case study linked below, complete a treatment plan. Remember that the Treatment Plan needs to follow this exact format and needs to incorporate S.M.A.R.T. goals.

Submit your complete paper to the appropriate drop box.

Grading Rubric for Chapter 3 Assignment

HERE IS THE CASE STUDY

Stella

Stella, a 45 year-old, married, nurse contacts you for psychotherapy. As you attempt to set a clinical interview appointment, she confides in you that she has not been able to leave her home for the past eight years. If you are unwilling to conduct the interview and testing in her home, she will likely not be able to receive treatment. After much thought, you decide to take her as a patient.

During the interview at Stella's large home (obviously upper middle class income level), Stella tells you that she has suffered from a fear of birds since she was a small child. Apparently, when she was about three, she went to a pet store with her brother and grandmother to buy some goldfish. Upon becoming separated for a short time, Stella wandered over to the bird section and attempted to pet a bird in the one cage she could get her hand into. Before she knew what happened, the large Parrot snapped off two of her fingers. It was at this point that the fear began.

Stella's grew up in a large, Italian-American family with many relatives. She mentioned that, though she was afraid of birds, she still was able to go to school and function fairly normally. The bigger issue was the disability she faced with only a thumb, second finger and pinkie on her right hand (she is right-handed.) With physical therapy, she was able to use both hands fairly well. She eventually gained enough control of her hands to allow her to play the piano and manipulate a flag in the color guard of her high school. Stella was always uncomfortable with birds and avoided the zoo and parks. Otherwise, she developed in a rather typical fashion.

In college, Stella majored in nursing. While on a clinical rotation at a local hospital, she met a young intern (Dave). They dated for about a year and married. Stella worked full-time as a nurse until her second daughter (Melissa) was born. At that point, she became increasingly uncomfortable leaving her home. When Melissa was about two, Stella finally decided to stay home to raise her children. (Her oldest daughter, Ashley, was three). Dave was largely supportive of the decision to stay home as he was unaware of her difficulty leaving the home. Over the next 19 years, Stella has increasingly become withdrawn and anxious about various things in her life.

The main focus of her anxiety is being unable to escape if she becomes trapped near a bird.

Although she was increasingly anxious, Stella was able to get out sometimes, especially as she had the help of a Nanny to take the children to various appointments and practice sessions. At that point, she was able to go to the grocery store, meet friends for lunch and basically live her

life without too much difficulty. At some point about eight years ago, Stella found it more and more difficult to leave her home. She gradually stopped going out at all. She relied more and more on Dave and the Nanny. Further, even while at home, Stella found it difficult to be completely calm. As a result, she had the gardener cut down the threes on the property and eventually had the fireplaces "bricked-in" so birds would be unable to fly into the house. She also did not allow feather dusters, feather pillows, down-comforters or stuffed toy birds into the house. Her housekeeper was severely reprimanded for using a feather duster on one occasion.

Stella's medical history is rather unremarkable, with no current illnesses or diseases. She denies a history of surgeries or atypical illnesses. There is also no history of diagnosed mental illness in her family. At this time, she takes no medications other than the Xanax that Dave prescribed (very unethically) for her "spells." When questioned about her "spells," she described periods where she is unable to breathe well and fears that she will choke. Her heart also pounds and she becomes quite dizzy and disoriented. The severity of the spells varies from event to event. When asked about their frequency, she estimated about once per week and tend to be triggered when she sees too many birds outside. She usually will close the curtains for the remainder of the day to help her remain calm. Most of the spells last between 10 and 20 minutes, then subside leaving her exhausted and tearful. She estimated that the

spells began about 9 years ago and have happened more frequently on a fairly consistent basis.

When asked why she sought treatment now, Stella began to cry. Apparently, her husband, Dave, gave her an ultimatum. He told her that either she receive treatment or he was going to leave the marriage. This caught Stella off guard as she said that their lives were pretty "normal." She loves to cook, so they entertain family and friends frequently. They lead a full life, as Dave goes golfing with his friends and her children are busy with school and boyfriends. Stella continued to weep as she discussed that no one knows about her "problem" other than Dave and the kids. At that point, she confided in you that she is certain that Dave is having an affair with a woman at the office. She said she has no solid proof other than intuition.

Dave and Stella's daughters, Melissa, 20 and Ashley 22 are finishing their undergraduate work at Saint Joe's. Melissa is majoring in psychology and wants to be a clinical psychologist ("because she thinks I am crazy," said Stella), while Ashley is currently applying to medical schools throughout the US. As she talked about her daughters, Stella began to have difficulty breathing and took a Xanax. Through tears, she told you that her greatest fear was that, if Dave left, they would go live with him. She further talked about feeling like a failure as a mother and wife. These feelings overwhelm her at times and she dissolves into tears. Periodically, she just feels that life isn't worth living.

On the MMPI, Stella showed clinical elevations (above 75) on the D, Pt and Si scales. Her Manifest Anxiety Scale and Beck Depression Inventory results showed clinical levels of both. On the projective instruments, she showed themes of loneliness, helplessness and suicidal potential. For example, the TAT was replete with stories of fear, death, loneliness and struggles to overcome obstacles. The suicide potential measure on the Rorschach was highly elevated, but when asked about suicidal thoughts or plans, Stella emphatically denied any. She stated that as a Catholic, she would commit a mortal sin if she were to kill herself. There is also no family history of self- harm or suicide.

Upon further questioning about the test findings, you find that Stella has tremendous difficulty sleeping (she wakes up quite early in the morning and can't get back to sleep.) She also has times where she really doesn't have much of an appetite. She loves to cook, but she just doesn't feel all that hungry. Her weight tends to fluctuate plus or minus 10 pounds every 6 months or so. Also, Dave and Stella have not had a consistent sexual relationship for about five years. She tends to avoid sex, as she feels it is more work that it is worth. They have had many arguments over her "coldness." Typically, she cries and leaves the bedroom. Unfortunately, they never resolve the conflicts and each time they occur, the intensity increases. At the time of the interview, it has been at least six months since they had intercourse.

On the Mental Status Exam, Stella presented quite well-dressed and appropriately groomed. She was of normative weight and appeared a bit younger than her stated age of 45. Overall, her mood was depressed with periods of tearfulness. Her physical movements were a bit slow and lethargic while her thought process was highly negative with evidence of helplessness and hopelessness. For example, when asked how she was coping with her panic attacks, Stella said she just lay on the couch and prayed they would pass quickly. She further stated that she gave up trying to control them years ago. She verbalized that "nothing will ever make them stop." Processing time also seemed to be a bit slow. At times she seemed to have difficulty concentrating and asked several times that a given question be repeated. Stella was oriented times four and able to participate fully in the interview and testing. The only unusual behavior during the interview was the use of Xanax when she became slightly anxious.

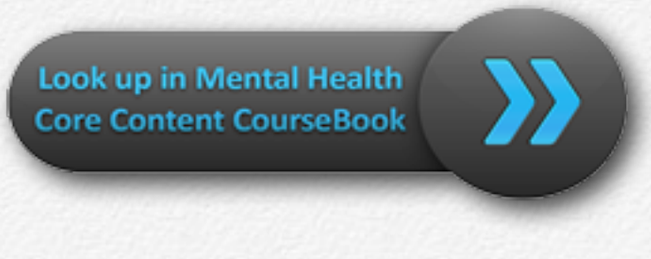
Upon diagnosing Stella with Agoraphobia with panic attacks and Major Depressive Disorder, you refer her to the Psychiatrist at your practice to for a medication evaluation. Along with the early learning experiences (Classical Conditioning) that have led to her phobia, your assumption is that Stella has gradually developed a decline in the neurotransmitters serotonin, norepinephrine and dopamine. Stella is given Zoloft (50mg 1 time per day), and Ativan (1 mg 3 times per day). She is asked to NOT take Xanax anymore. As the treating clinical psychologist,

you begin psychotherapy. Your plan is to begin Systematic Desensitization exercises in her home and transition her to the office as soon as possible. You will couple this with supportive psychotherapeutic interactions designed to build trust with the therapist. The marital and family issues will be dealt with as she stabilizes.

Based on your understanding of how clinical depression works, you tell Stella that she has a very good chance of recovering if she stays on the medication and continues psychotherapy. You also know that about 23% of women will suffer from this dis-

order at some point in their lives, with around 12 percent diagnosed in any given year. Depression may or may not get better on its' own, yet, most people with clinical depression will have another recurrence at some point in their lives. With effective treatment, solid improvement will usually occur within 3-6 months. Subsequent episodes are more quickly and effectively treated if the patient has been solidly responsive to the medication and psychotherapeutic interventions during the first episode.

Use the link below to review the Treatment Planning process in the Core Content CourseBook.



Text Link

MI: Engaging

4

Attention

Engagement

It is the same with teaching, counseling, and selling cars...if you cannot capture the attention of your audience you are not going to be effective!

One of the key philosophies of our work is that we want our clients to be the CENTER of the process. There will be times when clients with "check out" and not participate, preferring to simply let things go or allow you to do the work. We need to FIRST build a relationship with our client so that we can help each client become an engaged part of his/her own treatment and recovery.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss the importance of establishing rapport.
2. Demonstrate effective use of OARS methods in a conversation.

Teaching

Engaging

Read pages 9-12 in the CCNC Motivational Interviewing (MI) Resource Guide.

As you have just read, establishing rapport is a key predictor of client success. We are able to have our clients more ENGAGED and we have more INFLUENCE on them when we have established a genuine relationship with them.

This is where our interpersonal skills come into play.

While at some times our clients want to get right to solving pressing problems, we often have the time to get to know our clients. This step in the process can be rather casual. For instance, I have talked about personal likes and dislikes in music or movies as a way to focus the conversation on building rapport. One client in particular would not talk to me until he found out I liked Pink Floyd!

The real skill is learning how to establish rapport while at the same time gathering the information you need early on to move toward treatment planning. If you take too much time developing rapport you will run out of time to create a treatment plan outlining your future work together. In Maine most third party payers (the insurance company paying for the service) allow a mental health worker about 30 days from the day a case opened to the development of a complete treatment plan written, reviewed and signed off on by the client.

How To Build Rapport With Clients

by Dr. Barbara LoFrisco

Posted on December 6, 2012

https://www.mastersincounseling.org/how-to-build-rapport-with-clients.html

Building rapport with your clients is one of the most important counseling skills to possess. Did you know that approximately 40% of client change is due to the quality of the counseling relationship? It's no secret that we must get clients to trust us and feel comfortable in the counseling room. If we don't, then clients won't share important details with us, won't trust what we say, and in general won't participate in the counseling process in the way that we need them to. But how do we build this rapport?

Here are some suggestions:

Suggestion 1

Use your active listening skills to understand the client and their story. Before you make any attempt at an intervention, demonstrate to the client that you understand where they are coming from.

Suggestion 2

Watch your speed. Your speed of intimacy, that is. Depending on the client's culture, background, personality, etc., it may take longer to build the trust required to discuss more personal and sensitive issues. In order to assess the trust level, pay attention to both the content of what the client is sharing (some clients will only share surface-level details at first) and the client's body language, as they will be important indicators of how much the client is ready to share. It is important to be aware of these non-verbal signals because not all clients will clearly verbalize their discomfort.

Suggestion 3

Small successes first. Before delving into their biggest problem, try giving helpful information, positive feedback or encouragement. You may even try to help by making a plan to address a smaller problem early on in the process. But at this stage only attempt those problems you are reasonably confident you can address successfully. This will help the client build confidence in you.

Suggestion 4

Treat the client with respect. This may seem obvious, but from your very first contact treat the client as an important person. Return calls promptly, arrive to appointments on time, dress professionally, have paperwork ready for them, etc. Respect their time as much as you do your own. (Which you should, or we need to be having a different type of conversation). Imagine how you would like to be treated as a client, and adjust your behavior accordingly.

Suggestion 5

Be competent. It should seem obvious, but probably the best way to destroy a counseling relationship is to be incompetent. The client isn't going to trust you if you don't know what you are doing. Ensure you have proper training and experience before tackling the client's issue. Be forthright with the client about how much experience and the scope of what you can assist him or her with during one of your first contacts. In the end the clients always have the decision of whether or not they want to work with you. It's really their decision, not yours.

Suggestion 6

Self disclosure. Disclosing small strategic pieces of personal information is also another way to build rapport but be careful with this one. Too much disclosure, too personal, too much focus on you - not the client, or done too early or for the wrong reasons can easily backfire.

Remember, the counseling or interpersonal relationship is really the most important factor in the room. It matters more than the theory and interventions you use.

Attending

Paying Attention

Have you ever tried having a conversation with someone who was not attending or paying attention to you? They were distracted? Maybe not making eye contact? How did you know they were not attending? What did you do?

In our busy lives we can sometimes fail to attend to what is going on around us. Add to this the allure of technology and our ability to remain "connected" but what are we connected to? What is the effect of all this technology around us on our ability to attend to what is going on?

As counselors we develop a comfortable "vigilance" as to the behavior of our client. It does not read as clearly as words, but they are taken into consideration when we work with clients.

- Visual/Eye Contact
- Vocal Qualities
- Verbal Tracking
    - Key words
    - Emotion words
    - Contradictions
- Body Communication

OARS

We will be revisiting these skills throughout the course. Despite the fact that they appear at the beginning of the process, they are actually continually used throughout the process!

Referring to the table on p. 11 (CCNC Motivational Interviewing (MI) Resource Guide) we see that our interactions with our clients need to be full of statements like these that build rapport.

OARS stands for:

- Open-ended Questions
- Affirmations
- Reflective Listening
- Summaries

OARS and MI Principles

This small collection of skills, when used appropriately, sends a very clear message to our clients: "You are important and I am listening to what you are saying." During any interaction we have with someone else, isn't this how we all want to feel? That the person we are talking to cares and is paying attention which has me feel that I am important and valued.

We are moving our clients toward a point where they establish a sense of self-efficacy ("I can do it!")...while this is not the same as self esteem, ensuring that our clients know they are important and worth listening to is a step in that direction!

Text Link

Text Link

Text Link

Importance of Empathy

Text Link

Assessment

Chapter 4 Discussion A

I want you to engage a significant other in a discussion. The topic can be about anything you wish to talk about. In this conversation I want you to be very attentive as to the body cues you are receiving from the person. At some time during the conversation, when they are trying to tell you something, make an effort to be distracted and "not listen". (Be sure to continue attending to body cues.)

After a short time the individual may become irritated so be ready to stop the experiment and tell them what you are doing! Ask them how it felt to be "not listened to."

Describe this experience and any other experiences you may have had when you did not feel attended to. Considering the stigma that many of our clients experience due to their physical or psychological disabilities, describe how they might experience not being attended to and why it is so important for us, as mental health workers to pay attention to our clients.

Chapter 4 Discussion B

Why is it important to establish a "friendly" rapport with your clients? If you have a story to tell, describe a situation in which a person who was helping you DID or DID NOT establish this rapport. What was the outcome? (Note that the goal of building a "friendly" rapport is not to become their friend. You must always maintain appropriate professional boundaries.)

MI: Focusing

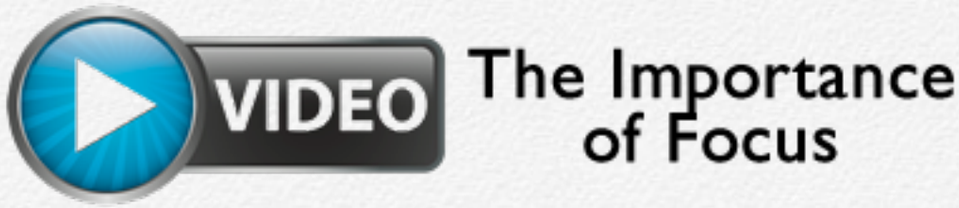
5

Attention

Focus

This TEDEd has a lot to do with success in general and the importance of FOCUS in particular.

We can teach our clients (and ourselves) to FOCUS by orienting ourselves to long term goals and to short term concentration.



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Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss the relationship between goals and commitment to attaining a goal.
2. Demonstrate the ability to focus within a session.

Teaching

Focusing

Read pages 13-18 in the CCNC Motivational Interviewing (MI) Resource Guide.

Ultimately our presence in a client's life is as a "change agent." This means we have the role of facilitating a change in a person's life (internal or external) so that they can attain their goals.

Change can be, however, very difficult.

The Focusing stage of MI allows us to help clients prioritize their goals and determine how motivated they are to engage in the change process.

Focusing the Session

It is important that both the client and the counselor decide upon a focus point for each session. Focal points can be a review of past progress, the exploration of a new goal, the establishment of a new plan, etc.

Either way, sometime in the beginning of the session, the Counselor should say to the client something along these links:

"So, based on what I'm hearing, it sounds to me like you would like to use this session to...(insert thoughts here). Is this correct?"

This step in the process will then allow the counselor and client to move forward and spend the rest of the time working toward that end.

A meandering session that just goes from one topic or subject to another is not productive. You are there to provide a service to your client, and often that service manifests in helping them focus their energies on solving problems. A "lack of focus" often a core issue with clients. Having so much going on at one time they can feel overwhelmed and end up getting nothing done at all.

Focusing Techniques

Below are some techniques that can be used to help the client focus the sessions.

Agenda Mapping

This process provides a laundry list of the current issues/goals/problems.

Giving Information

Here you are sharing YOUR expertise. Keep in mind though, that the "Elicit/Provide/Elicit" model is important in that it allows you to NOT play the role of "having all the answers." You ultimately want your client to come up with ideas based on their experience and history.

Establishing the Patient Dilemma

This is where you use open ended questions to help create the vision of what they might like to see or do differently. (Remember, this is working toward a larger Treatment Plan...that is different than the Brief Action Plan that we put in place to address immediate needs.)

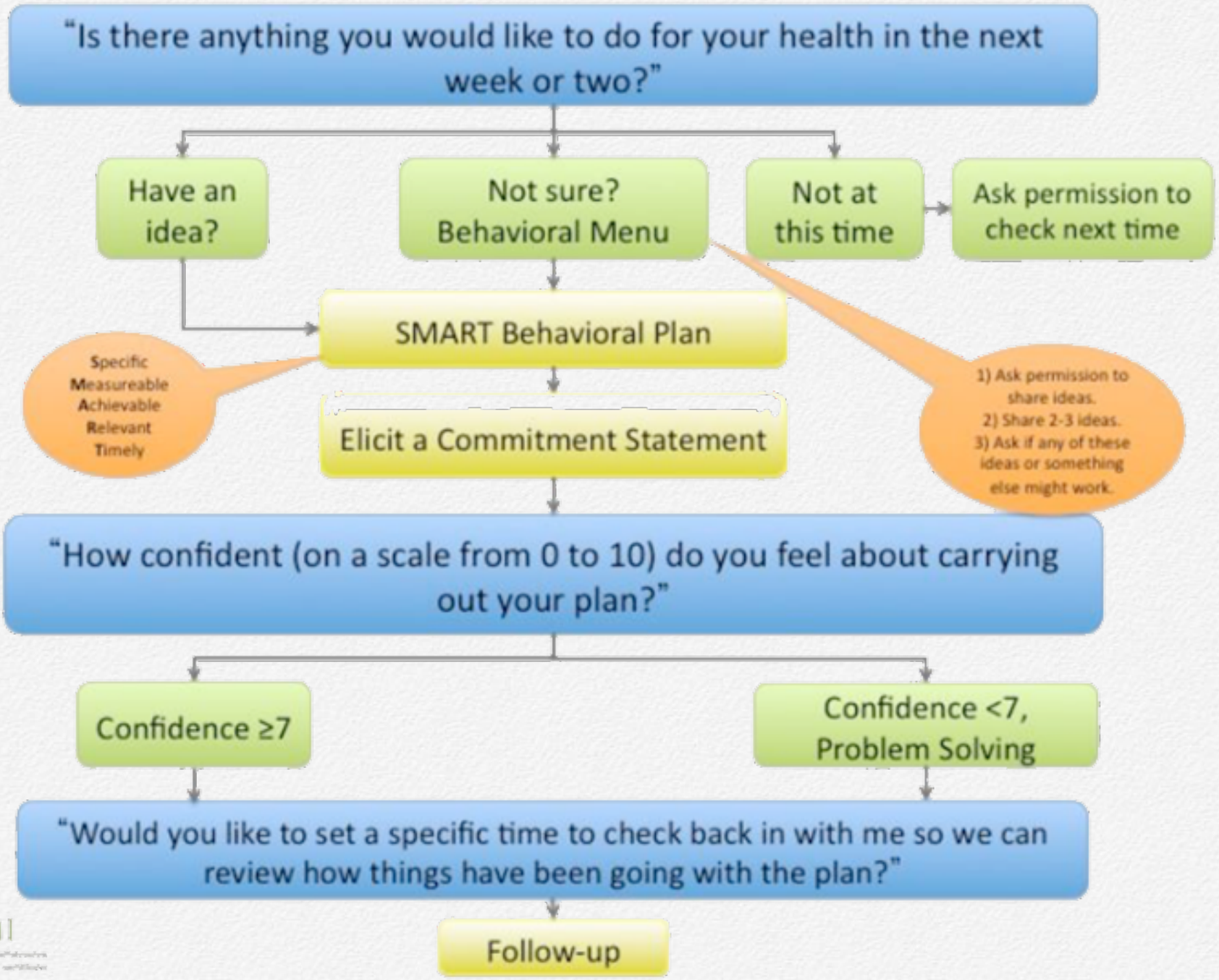
Brief Action Planning

(with S.M.A.R.T. Goals) - This is a tentative plan that addresses the most pressing issue.

For this Lesson, and anticipating the Lab described below, let's look at the Brief Action Planning step. Ultimately this is not very different than the conversation we would have with a client when we are establishing long range goals. For convenience I have copied the graphic from our CCNC resource here.

This graphic outlines the process and steps you take to have a conversation with someone about their goals and plans to address their goals. The orange balloons identify skills such as the development of S.M.A.R.T Goals and the "Giving Information" step outlined above. Notice where you place these behaviors in the process! IF the client ALREADY has an idea, go with that one! If they are not sure, then you might offer ideas.

Too many times we may have a "solution in search of a problem" based on our own persona experience and knowledge. There will be a time for us to offer these up but unless the person has no idea as to how to approach accomplishing their goals, we don't have to yet offer advice.


"Is there anything you would like to do for your health in the next week or two?"
Have an idea?
Not sure? Behavioral Menu
Not at this time
Ask permission to check next time
SMART Behavioral Plan
Specific
Measureable
Achievable
Relevant
Timely
1) Ask permission to share ideas.
2) Share 2-3 ideas.
3) Ask if any of these ideas or something else might work.
Elicit a Commitment Statement
"How confident (on a scale from 0 to 10) do you feel about carrying out your plan?"
Confidence ≥7
Confidence <7, Problem Solving
"Would you like to set a specific time to check back in with me so we can review how things have been going with the plan?"
Follow-up

Assessment

Chapter 5 Discussion

Change is sometimes difficult, even when making that change will result in a better quality of life. Many people have goals that they never attain because they are fearful of the change and/or the expectations required of them to bring about this change or the expectations of them after the change.

Consider people in your life (possibly yourself!) and the relationship between having a goal and the actual motivation to achieve that goal. How is this relationship important in working with individuals with mental illness?

Chapter 5 Assignment

Focus on Medications

Place yourself in the situation in which a client has approached you with complaints about taking medication. They would like to stop taking medications all together, even though, from what you know, it could be dangerous for this person to do so.

Do some research to prepare yourself for this conversation by developing an “agenda map”. This “laundry list” of issues and such can b made up of information on the medication, history of the client’s struggles with symptoms, processes by which a person would change their meds (or reduce/stop their meds), potential side effects, etc.

You are preparing the kind of information you need to have a good discussion with the client about their meds.

You will make up a client and make up the medications they are on. The information on the diagnosis and medications, however, must be cited in this paper and be from reliable sources.

Your paper should clearly outline the kind of information that you and your client would need to make an informed decisions about medications.

Grading Rubric for Chapter 5 Assignment

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

MI: Evoking

6

Attention

Comfortable?

Change can be uncomfortable...even change that seems obvious and necessary. It is important that we understand that for most people, change implies some degree of fear and discomfort.

Great things never came from comfort zones.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss why the step of Evoking is such an important aspect of the MI process. to explore client motivation to change.

Teaching

Evoking

Read pages 13-18 in the CCNC Motivational Interviewing (MI) Resource Guide.

"Motivation" is a key term in the title of this model, and the Evoking step is all about exploring this motivation.

At this point in the process you have Engaged the client in the process by listening to them and having them tell their story and you have identified both long and short term issues to focus your work on...the next step is to explore, more deeply, the motivation someone has to change. This is the KEY step in this process.

Jumping to Conclusions

When we first start learning the process of Motivational Interviewing (and Counseling for that matter) we can often put a lot of pressure on ourselves for being able to come up with the "plan" or the answer to the problem situation.

While we ARE responsible for creating a problem-solving focused conversation, we are not necessarily responsible for coming up with the actual answer. In fact, our tendency to jump to quick answers can lead to trouble.

Need to be "Helpful"

Reflect on why you are entering this field. For many of you, you enjoy the process of helping others. Helping others makes you feel good. While the desire to help others is a driving force in this field, it is can also be problematic if we don't engage in a lot of self-examination.

From a social interaction standpoint, being the "helper" is actually a bit of a "power position". The one who is asking for help actually puts themselves into a "one down" position (this is why it is difficult for some people to ask for help - or directions!) Being the helper can become very much part of our identity. This sets us up to be challenged when we face any of the following possible circumstances:

1. We discover that we do not have the skills necessary to help someone with a particular problem.

2. The person we are trying to help can be better helped by someone else.
3. We attempt to help a person and they reject our advice.
4. We are “fired” by a client.
5. We do “all the right things” and our client is not successful.
6. Our client seems to “sabotage” all the work we did.
7. When we are working harder that our clients to make something happen.
8. When one of our clients commits suicide.

Problem-Solving Bias

Another aspect of ourselves that we need to look out for is the bias we have toward specific problem-solving strategies.

In this program we have you examine your own approaches to problem-solving and success in your own life. This process helps you identify the ways YOU were able to overcome your own barriers. While these are your strengths, they are also your biases. We are very quick to assume that the actions we took to solve our own problems should work with other people. This is not always the case.

We are not saying that you should never suggest your own path as a path that someone else could follow (our self-help groups are full of these suggestions). However, you have to remain open to finding out what will work for your client.

Who has the answer?

When you are quick to put forth the answer for your client, you will likely engage either 1) a strong agreement by your client which may indicate they are simply “going along” with your plan and they are not owning the plan, or 2) a series of “excuses” or “reasons” why your plan will not work.

Either one of these circumstances does not assist the process.

The answer can usually be discovered within the client!

Consider this. You can move the conversation in such ways as the client can come up with their own plan! You can use your verbal skills to “nudge” clients in one direction or another without being explicit about what the solution might be. This takes time to master and it can take a lot of time in a single session to do this, but the ultimate solution to the problems in people’s lives exist within the person themselves. You simply need to help them find their own answer.

Why change?

Many people have goals and desires that are never realized. One of the ways in which explain this is by saying..."Well, they never really wanted it anyway."

While this may be true, it is a bit premature to assume that a person did not really want it every time someone does not attain a goal. However, having a deep understanding of WHY we want a goal is key to building up the energy and desire to take the steps needed to achieve that goal.

On p. 19 in our CCNC Guide you can find the following:

Use OARS skills to explore patient's motivation, goals, and ideas/their own reasons to change.

We want to ask the WHY questions a lot. Even if it seems repetitive and obvious. Make sure that your client understands their own motivations and emotions (covered later) for entering a change process.

Identify and resolve barriers to change.

This is where we confront the internal and external barriers to change. We need to counter the attitudes, expectations, and other real barriers to change. In fact, a lot of our planning may focus on removing specific barriers.

Focus on past successes.

We are continually focused on our clients' strengths. Regardless of their past and circumstances, they have had successes in the past. Begin to explore how the skills used in other circumstances will help them in their current circumstances.

Understand impact of significant others.

Bring others in for support! Change works a lot better when others are there to help and support the person through the process.

Preparation - specific steps, dates, supports, resources, etc.

As you are going through this process you are beginning to formulate the specifics of the planning process you will engage in next.

This lists outlines the areas to explore in order to evoke someone's motivation!

On p. 22 of our CCNC Guide you can explore the EARS model of evoking and discussing motivation:

- Explore/Elaborate
- Affirm
- Reflect
- Summarize

The examples of these skills outlined in the box provide you with a good starting point as to how you incorporate these kinds of skills into your own process.

In this stage we are really mining for ideas and motivation within the client. This is where “the rubber meets the road”, as they say!

From these conversations we begin to get the details that we need of the current barriers, challenges, thoughts, perceptions, potential solutions (and those that did not work in the past), and emotions around solving the problem that is a focus of the session.

If we can effectively use these skills, we are much more likely to come up with potential solutions (plans) and we are much more likely to get significant buy-in by the client.

With these skills we are not always under pressure to come up with the solutions!

Responding to Change Talk: EARS!

Elaborating:	In what way ?; Tell me more ; What else?
Affirming:	That took a lot of courage; You’re a person who can make changes when you need to
Reflecting:	That’s really important to you ; You realize it’s become a problem
Summarizing:	There are a number of things I’m hearing about your situation . First, you’re concerned about .. Also, you feel , and you are thinking

Assessment

Chapter 6 Discussion A

Discuss the section on the “Need to be Helpful” and “Problem-Solving Bias”. What personal experiences can you share that exemplify the need to be aware of these aspects of your personality and approach?

Chapter 6 Discussion B

In relation to the EARS model, discuss why you think Affirmation is so important in the process of working with clients with mental illness in this way.

MI: Planning

7

Attention

Do you have a plan?

This graphic depicts a lot of the questions that we ask in the planning process, but it also shows something else...the answers to these questions are WRITTEN DOWN...there is

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss the challenges and importance of transitioning from "talk" to "walk."
2. Create a personal plan for the completion of the requirements in this class.

Teaching

Planning

Read pages 23-25 in the CCNC Motivational Interviewing (MI) Resource Guide.

We have now arrived at the point in the process where we are PLANNING for change. Over the course of the previous steps in the MI process we have been gathering information (identifying problems and barriers, skills, resources, etc.) and have worked on motivation (the "why" behind the goal). Now we have to piece together the ACTUAL STEPS we are going to take to bring about change.

This is where the "rubber meets the road!" What this means is all the TALK (discussions about change) now has to transition into WALK (taking specific actions to bring about the change.) There are numerous challenges that may come up that thwart this process.

Challenges to Treatment Planning

Keep in mind that when we are talking about change, the talk is relatively safe and unchallengeable. However, as we begin to approach the implementation steps, we can run into trouble. Three major models of understanding resistance to change are important to cover here as you will encounter them in your practice. They are:

- Fear of Failure
- Procrastination
- Rehabilitation Crisis

Fear of Failure

When faced with a task you want to complete, there is always the risk of failure. The possibility of failure is an important component of success...we will try harder if there IS a possibility of failure. However, if a person becomes TOO anxious about failure, or has a tendency to globalize failure to their sense of self ("I failed therefore I am no good at all.) then "Fear of Failure" can become problematic.

Atychiphobia is the term used to describe an "abnormal, unwarranted, and persistent fear of failure." This is very rare, but can appear in small doses!

Check out this article in Psychology Today about 10 Signs You Might Have (too much) Fear of Failure.

According to Vanessa Loder at Forbes Magazine, there are you can conquer Far of Failure with 5 Proven Strategies.

Procrastination

The first thing I want to say about Procrastination is that it is NOT a personality type. People are not categorized into those who do and do not procrastinate. Procrastination is a behavioral pattern that people learn.

Procrastination is caused by a combination of two things: (1) Fear of Failure and (2) the relationship between High Cognitive Load tasks and Low Cognitive Load tasks.

To explain this in depth and to provide an effective time management tool to combat the Hi/Low Cognitive Load issue, I have prepared a presentation called "The Psychology of Procrastination".

The Psychology of Procrastination
Dr. Mark H. Kavanaugh, PhD.

What is Procrastination?

In essence, Procrastination is the practice of carrying out less urgent tasks in preference to more urgent ones, or more pleasurable things in place of less pleasurable things.

Is Procrastination a Problem?

Yes, it can represent a severe problem to success not only in school but in health, family, career, etc.

Does Procrastination mean I'm Dumb?

Procrastination is a habit like any other "bad" habit you may have. What makes a person "dumb" is refusing to do anything about it!

The Psychology of Procrastination

Psychology seeks to describe, explain, predict, and ultimately control behavior. Psychology has a pretty good handle on what procrastination is and what you can do to change this habit. The question is...do you want to change?

Two major concepts are involved in the understanding of Procrastination:

- Low and High Cognitive Load Tasks
- Fear of Failure

Low and High Cognitive Load Tasks

This relates to the definition of Procrastination at the top of this page. Consider low cognitive load tasks as "less urgent" and "pleasurable" while high cognitive load tasks are "more urgent" and "less pleasurable".

Time for an example:

Washing the Dishes
vs.
Doing online research to find Peer Reviewed articles for a Paper

WHICH IS LESS/MORE URGENT? WHICH IS LESS/MORE PLEASURABLE?

Here it is...just like in the definition...we Procrastinate when we choose to do Low Cognitive Load Tasks and ignore High Cognitive Load Tasks

This is the basic PLEASURE PRINCIPLE from Freud...we will seek out activities that give us PLEASURE and move away from activities that give us PAIN.

Values and Low Cognitive Load Tasks

One of the most common tricks we can play on ourselves it to VALUE the Low Cognitive Load Tasks very high.

Example: A GOOD MOTHER has a clean house, attends to all the kids' needs, cooks amazing dinners, etc. etc. (Yes, it can be a FATHER too!)

We use this EXCUSE to PRIORITIZE Low Cognitive Tasks because being a good parent is so important to us!

Fear of Failure

Psychologists and educators (and Olympians) have known for a long time that if there is a real possibility of FAILING, people may work harder to make sure they don't fail. This is the STRESS you feel when you are about to be tested or when you have to do a paper. (That is IF you value grades as a part of who you are and who you want to be.)

Some people are MORE sensitive to this than others...which makes some people work harder to avoid failure when others don't.

BUT...there is a confusing trick. Consider this statement and if it is true:

If I don't hand in the assignment and I fail that is better than handing in the assignment and failing.

Saving Face with Procrastination

Sometimes our Fear of Failure can get the best of us and we make an unconscious decision to NOT try and thus the above statements helps us save face (we might even RATIONALIZE that IF we HAD submitted the assignment, we would have been fine...but...well, I was being a GOOD MOTHER and the WORLD NEEDS GOOD MOTHERS!!!)

You see where this can go???

Ask Yourself Some Questions:

- Why do I need to succeed?
- Is my measure of "success" always to be the "best"?
- Who are the valuable people in my life that I'm trying to impress?
- Why do I think that failing makes me a "FAILURE"?

The VALUE of Failure

I'm going to counter each one of these questions with solid psychological advice...choose to take it if you wish!

Why do I need to succeed?

In actuality, you need to FAIL. You actually learn more by failing than you do by succeeding. Failure tells you what you need to learn, do, improve...succeeding (particularly getting a 100) tells you nothing. What do you know when you get a 100? You don't know!

Is my measure of "success" always to be the "best"?

This is indicative in our society. We are obsessed with the BEST of everything and we place high value on this. While there is nothing wrong with striving to be the best we have to see the value of doing MY BEST, not the best based on an outside measure...see the next one!

Who are the valuable people in my life that I'm trying to impress?

Don't tell me this is all for you...if that is the case, you are a very, very lonely person. We all have people in our lives whose opinions we value. We give them this power because we trust they will praise us when we succeed and help us when we fall. Are all the people on your list WORTHY of being there?

Why do I think that failing makes me a "FAILURE"?

This is that big "self-esteem" thing. But it really isn't self-esteem. It is WISDOM. Consider this play on the famous Serenity Prayer...

God, grant me the SERENITY to accept the things I'm not good at The COURAGE to focus on the things I am good at
And the WISDOM to know the difference

FAILURE ONCE AGAIN is the BEST teacher of what you are good at and what you are not good at...granted, you have to TRY hard and DO hard, but you do this with the mind of self-discovery as much as self-definition!

High and Low Cognitive Load Tasks

Contending with the BEHAVIORAL aspect of Procrastination is all about TIME and TASK management. Everyone in this room has the same amount of time a day and some very successful people are way busier than you are. How do they do it?

Time Management

You are in school to create a future for yourself...you ADDED this to your schedule so something needs to go! (BECAUSE SCHOOL IS MORE IMPORTANT)

- No more TV
- No more movies
- No more going out • Etc.
  You now have to EARN these things by doing the IMPORTANT THINGS!

WEEKLY CALENDAR ACTIVITY
IDENTIFY WORK WINDOWS IN YOUR WEEK

If you don't have enough of these then you will need to cut back or you will not be successful...or you will be sick...and not be successful)

Task Management (one day at a time)
Here are the steps that I take, mostly successfully, to take on High and Low Cognitive Load Tasks in a given day:

- List all the things I want to get done.
- Break down the tasks into smaller pieces (this might depend on your cognitive style)
- List the High Cognitive Load Tasks in order of importance
- List the Low Cognitive Load Tasks in order of importance
- Create a "To Do" list that alternates between High and Low tasks for the duration of my "Work Windows" in time increments that make sense to me.

Rehabilitation Crisis

One of the most fundamental developmental processes that occurs in the human lifespan is the development and affirming of Identity. Identity represents the internal "schema" or "concept" that we hold of ourselves. It is our own perceptions of who we are.

While the development of Identity is beyond the scope of this lesson let it be said that we rely on this concept to feel secure in the world. We seek stability in our work through constants and patterns and none are more important than the notion of a constant self. (Consider how unstable a person may become when aspects of themselves begin to change!)

So, here is what Rehabilitation Crisis is all about. As we have been talking about, our role is to facilitate change in a person, so we are constantly in a conflict between the forces that want to change a person (instability) and the forces that want to stay the same (stability). We should recognize that our work is fundamentally de-stabilizing in someone's life!

A person may have a Rehabilitation Crisis when they are approaching a threshold in their lives (starting a new medication, going to a job interview, beginning a new relationship) and they sabotage that change process in order to maintain their current concept of self.

This can be very frustrating to us as workers and very frustrating to our clients. The thought to keep in mind is that we are asking individuals to change who they are (and in some cases, to change other aspects of themselves such as how OTHERS perceive them, their finances, where they live, and the expectations others may have of them). These are fundamental and often scary changes for anyone to contemplate...even if the changes are in a positive direction! Remember, regardless of the QUALITY of a person's life, changes in identity are perceived of as INSTABILITY while staying the same is seen as STABILITY

Our best approach to Rehabilitation Crisis is to be open in our conversations with our clients about it. We should engage our clients in discussions about what change means and explore how the think and feel about these changes.

The Lifespan of Mental Illness

In Chapter 2, we examined the impact of age on our work. We recognized that our clients are progressing through the same developmental stages (described by the various models and theories that were presented) just like anyone else. Understanding where someone is at in terms of their normative developmental stage is critical to understanding how to work with that person.

Mental Disorders occur over time as well. While some symptoms may appear very early in life, there is often a point at which the illness is first recognized and diagnosed. From the developmental perspective, the timing of this “discovery” is important in regard to normative development, but the illness itself has its own path through time as well.

In this section we will examine the etiology (causes), progression, and treatment of major mental illnesses.

Stages of Mental Health Conditions

Stage 1:
Mild Symptoms and Warning Signs

At Stage 1, a person begins to show symptoms of a mental health condition, but is still able to maintain the ability to function at home, work or school—although perhaps not as easily as before they started to show symptoms. Often there is a sense that something is "not right."

Stage 2:
Symptoms Increase in Frequency and Severity and Interfere with Life Activities and Roles

At Stage 2, it usually becomes obvious that something is wrong. A person's symptoms may become stronger and last longer or new symptoms may start appearing on top of existing ones, creating something of a snowball effect. Performance at work or school will become more difficult, and a person may have trouble keeping up with family duties, social obligations or personal responsibilities.

Stage 3:
Symptoms Worsen with Relapsing and Recurring Episodes Accompanied by Serious Disruption in Life Activities and Roles

At Stage 3, symptoms have continued to increase in severity, and many symptoms are often taking place at the same time. A person may feel as though they are losing control of their life and the ability to fill their roles at home, work or school.

Stage 4:
Symptoms are Persistent and Severe and Have Jeopardized One's Life

By Stage 4, the combination of extreme, prolonged and persistent symptoms and impairment often results in development of other health conditions and has the potential to turn into a crisis event like unemployment, hospitalization, homelessness or even incarceration. In the worst cases, untreated mental illnesses can lead to loss of life an average of 25 years early.

Etiology

Etiology refers to the causes of something...in this case, the causes of mental illness.

Throughout history, the field of Psychology has put forth any number of reasons why mental illness appears. Everything from demon possession to poor mothering to brain chemistry imbalance has been explored as the root cause of these disorders.

Today, we see most mental illnesses as the result of brain structure problems, functional issues, or chemical imbalances.

Click HERE to read the APA article on the Roots of Mental Illness

Progression

From the point of diagnosis forward, there is a progression of the experience of mental illness. This progression relates to both the process of dealing with a mental illness on the part of the client and the actual ebbs and flows of the illness itself (what you may hear of as the cycles of the mental illness, or periods of relative “calm” and “stormy” times.)

On the following page there is a graphic that represents one model for how a person progresses through the stages of recognizing the symptoms as indicators of an illness through the development of a persistent and pervasive condition.

Cycles of Mental Illness

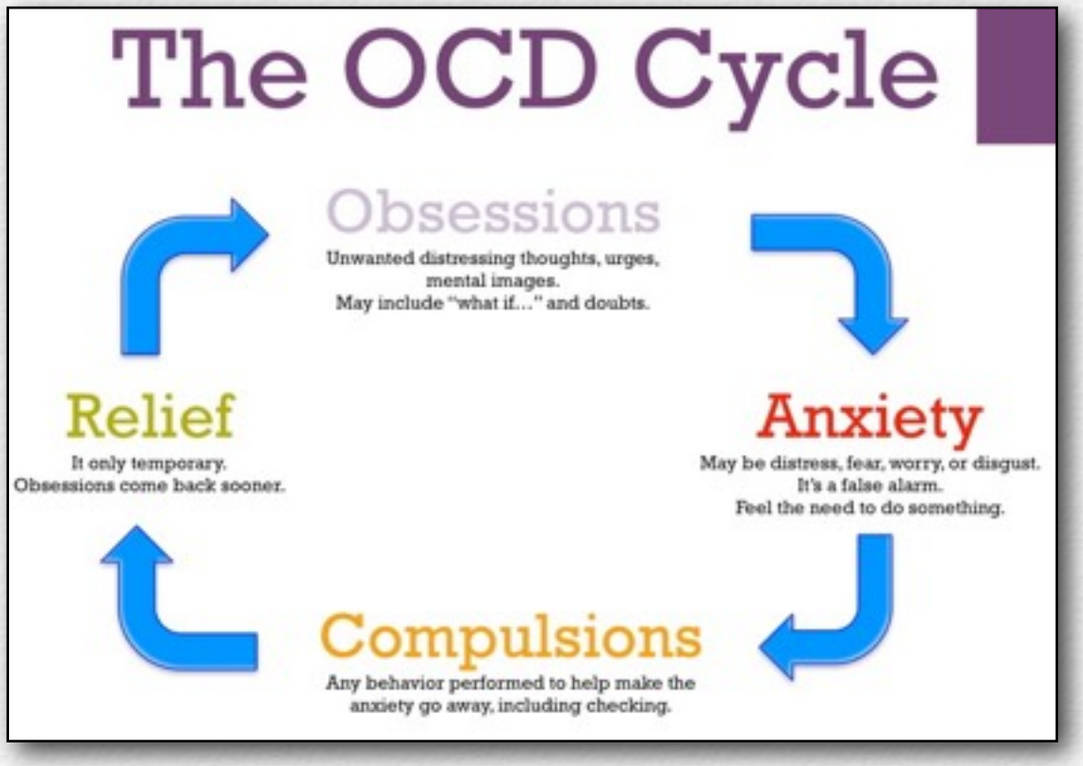
For many people with mental illness, there are periods of time where things seem to be going relatively well and other times where the symptoms are particularly present. This is somewhat controlled, in some circumstances, by medication.

This “cyclical” nature of mental illness is highly individual and depends upon lots of factors including individual personality, psychosocial stressors, climate and weather, financial issues, nutrition, and physical health and wellness.

Lets consider some of the major mental illnesses and take a look at the cycles we sometimes see happen. Be sure to not over-generalize this information as the cycle (or even IF the person experiences a cycle or not) varies a lot from person to person.

ANXIETY DISORDERS

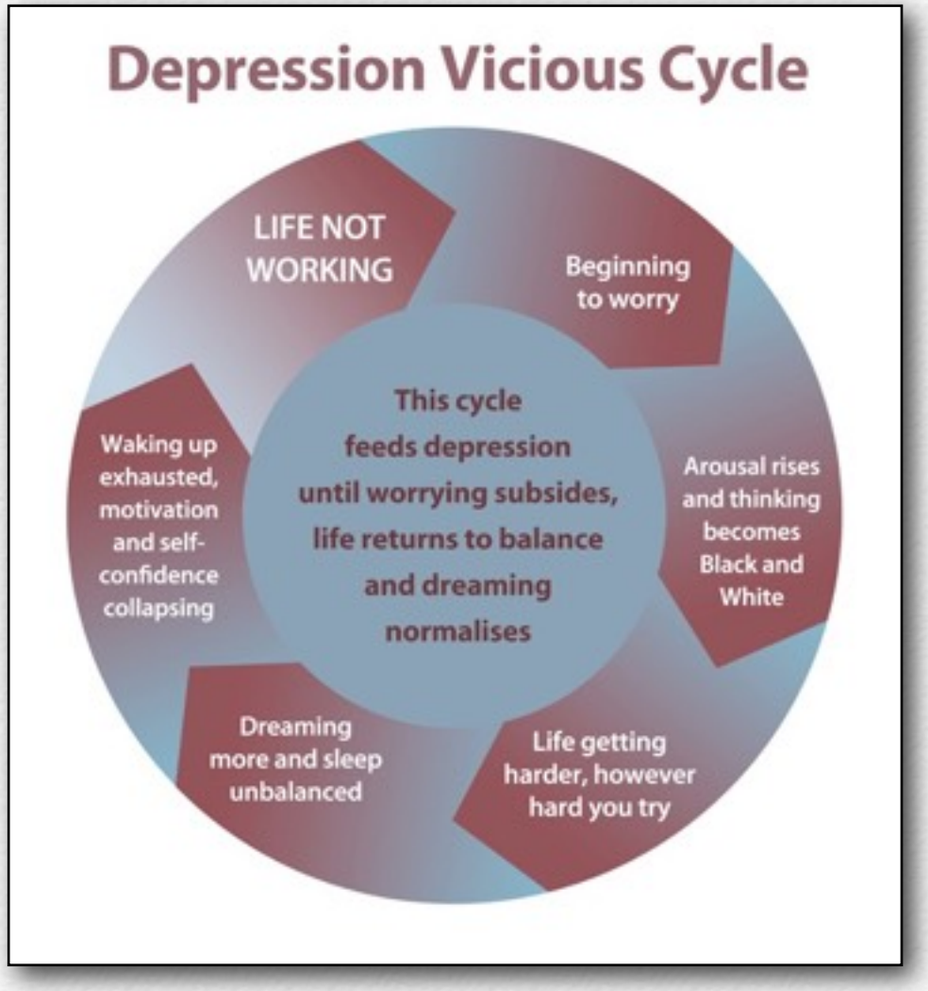
One of the most common of mental health conditions are those having to do with anxiety. While this graphic deals directly with Obsessive-Compulsive disorder, you can see that the actions that a person has to take (in this case the obsessions and compulsions lead to a cycle of anxiety and relief.)



DEPRESSION

Major Depression is highly reactive to psychosocial and environmental factors, but many experience a cycle of increased and decreased symptoms over time.

The following graphic outlines how changes in sleep patterns, thinking styles, and stimulation interact to create the "perfect storm" for a depressive episode.



SCHIZOPHRENIA

This graphic represents different phases in the presentation of different symptoms of schizophrenia over time. Sometimes presenting symptoms vary between “negative” (something, like emotions, are taken away) and “positive” (something, like delusions, are added).

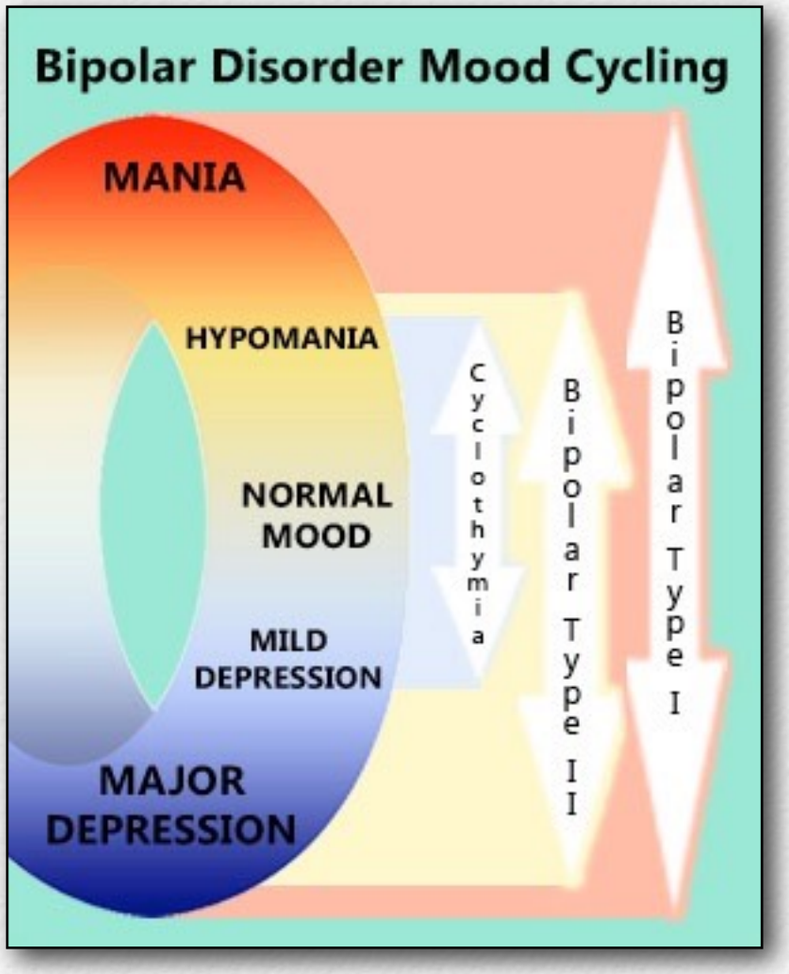
BINGE EATING (AND OTHER EATING DISORDERS)

While there are vast differences between the different eating disorders, this graphic well represents the cycle of interactions between the environment, self-image, and behavior.

BIPOLAR DISORDER

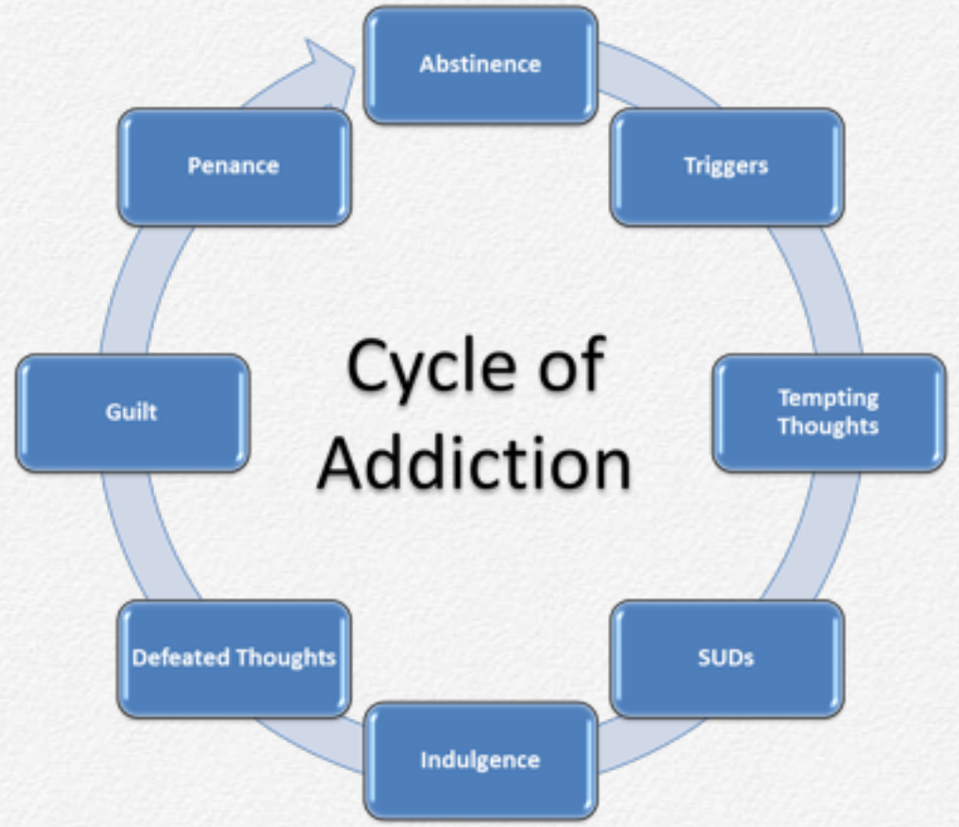
This graphic represents the varied degrees of the cycle that occurs with persons with Bipolar Disorder. The timing of the cycles can vary from hours to days to weeks for someone to cycle through a full manic-depressive cycle.

You can see the differences between Cyclothymia, Bipolar Type I, and bipolar Type II by the degree of the change.



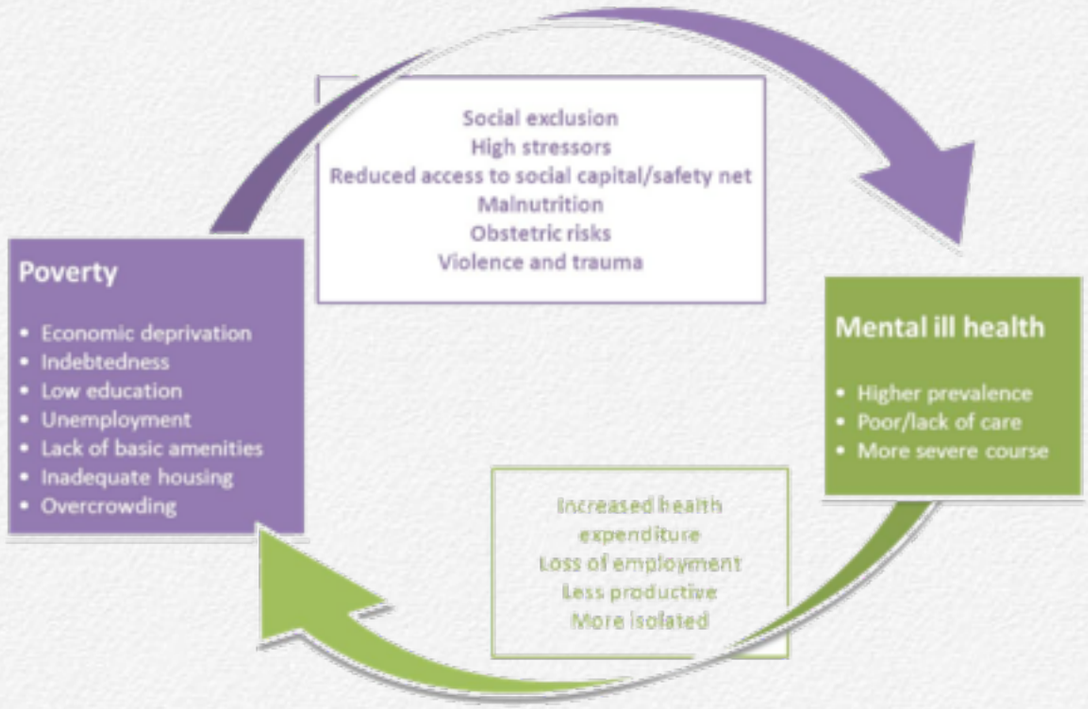
ADDICTION

In this cycle you can see how a person with any addiction can move from periods of relative abstinence or control of the addiction to periods of binge consumption. This cycle can be applied to just about any addiction: substances, gambling, sex, eating, etc



CYCLE OF POVERTY

Although this is not technically a cycle of mental illness, poverty is so closely tied to mental health issues is really should be present on our minds at all times. This graphic demonstrates the impact of poverty on connection to community and health (both physical and mental health.)



Keeping an Eye on where your Client is...

As we think about these different models, we need to continually take into consideration where someone is at developmentally, in regard to their experience of mental illness, the progress of their illness and symptoms, and their readiness to change (stages of change). Our clients are just as complex as any other human being in these regards!

Treatment

Finally, we look at the progression of treatment over time. Different conditions require different approaches so it is wise to familiarize yourself with the latest research on effective treatments for mental health conditions.

There are many different approaches to treatment. Some involve medical strategies (medication, surgery, and Electroconvulsive Therapy), psychotherapy (counseling, psychoanalysis, Dialectical Behavior Therapy, Systematic Desensitization), and, of course rehabilitation (case management, community supports, community integration, financial/employment/health services.)

Phases of Recovery

The following article is a key piece of work on the process of recovery from mental illness in general. Here is the abstract to this paper:

> *The purpose of this paper is to describe the phases of recovery from psychiatric disabilities and their implications for interventions. The paper identifies the many variables at work in recovery, including phases that occur over time, areas of development within which people change, developmental tasks and processes, and turning points that represent important shifts within the phases and within the developmental dimensions.*

Please take the time to read this entire article.

Spaniol, L. & Wewiorski, N.J. (2012). Phases of recovery process from psychiatric disabilities. International Journal of Psychosocial Rehabilitation. 17(1).

Four Phases of Mental Health Recovery

Here is another model called “The Four Phases of Mental Health Recovery” developed by The Center for Psychiatric Rehabilitation at Boston University. These four phases include:

Phase One: Overwhelmed by the Disability

- Feeling hopeless
- Feeling disconnected
- Survival is the main issue
- **Looking for…**
    - Good treatment
    - Meeting basic needs
    - Working with someone who is both competent and compassionate

Phase Two: Struggling with the Disability

- Asking “How can I live with this disability?”
- Learning active coping skills
- Rebuilding sense of self
- **Looking for…**
    - Acceptance by other people
    - Relapse-management skills and self-care skills
    - Connections with work, people, activities

    - Opportunities to take healthy risks
    - Psychotherapy

Phase Three: Living Well with the Disability

- Experiencing increased confidence and a stronger sense of self
- Connecting to work, people, activities
- Finding a niche
- **Looking for…**
    - People who can help me find satisfying work
    - Reconnection with family if desired
    - Opportunities to fill multiple roles
    - Financial security
    - Spiritual connections

Phase Four: Living Beyond the Disability

- Realizing that there is more to life than the illness
- Feeling well connected to others and the community
- Testing capabilities
- Finding new meaning and purpose in life
- **Looking for…**
    - Help in choosing, getting and keeping meaningful work
    - Positive relationships
    - Spiritual connections

Application of Developmental Theory

As discussed in Chapter 2, Erikson's Theory of Psychosocial Development can be applied to nearly every experience of personal change. In this article, the authors examine the application of Erikson's model to the process of recovery.

This is an excellent example of just how far reaching this work of Erikson has become!

Vogel-Scibilia, SE, Cohan McNulty, K, Miller, S, Dine, M, Frese III, FJ: The recovery process utilizing Erikson's stages of human development. Community Mental Health Journal 2009, 45:405-414

Assessment

Chapter 7 Discussion

As was discussed in this Chapter, Planning is where the "rubber meets the road." Talking about change is one thing, acting on it is another. Discuss the challenges and importance of making this step. Identify how an effective implementation of the previous steps in the MI process make THIS step more likely.

Apply this process to a single example of the cycle associated with a major mental health disorder. How does the MI planning process take into account the cycles that some persons experience?

Chapter 7 Assignment

My Own Treatment Plan

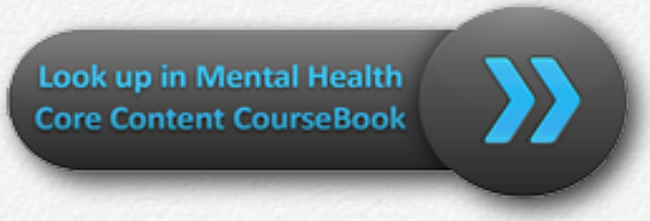
Using the planning method described in this Lesson, create a treatment plan for yourself that outlines how you are going to complete all the course requirements from this point forward. Compose this plan and submit it to the appropriate drop box.

At the end of the treatment plan, write a reflective essay about how the barriers to treatment and “Phases of Recovery” may be applied to your own situation.

Take into consideration the concepts of Fear of Failure, Procrastination, and Rehabilitation Criss. Reflect on your own experiences with these barriers to change.

Grading Rubric for Chapter 7 Assignment

Use the link below to review the Treatment Planning process in the Core Content CourseBook.



Text Link

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Motivational Interviewing in Groups

8

Attention

Working in Groups

At some point in our careers we may find ourselves practicing our craft in a group setting rather than the usual 1:1 setting.

This video depicts a behavioral health provider demonstrating "MI Consistent" smoking cessation group intervention skills. The provider models what providers should strive to do when facilitating MDQuit's Behavioral Health Smoking Cessation Group Intervention.

Text Link

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss the challenges and opportunities associated with the application of MI in groups.
2. Apply the Bowen Family System Model to the analysis of a family.

Teaching

Revisiting the Definition of Motivational Interviewing

"Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language go change. I tis designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the persons' own reasons for change within an atmosphere of acceptance and compassion." - Miller and Rollnick (2012)

The "Spirit" of Motivational Interviewing

- Partnership
- Acceptance / Autonomy / Absolute Worth
- Compassion
- Evocation

Key Principles

- Express Empathy

Listening to the client without being judgmental, critical, or blaming. In the early stages a person may not be yet willing to give up their behaviors.

- Develop Discrepancy

Helping clients see a difference between what they are doing now and what they want to be in the future.

- Roll with Resistance

Resistance will happen. The key approach in MI is to "roll" with the resistance. Reflecting back to the client the emotions that you sense and using the resistance to further explore their commitment to change.

- Support Self-Efficacy

Self-efficacy is the perception we have of our ability to do or accomplish something. We work to build our clients' confidence in their ability to bring about change...this ability can then be used to bring about other changes as well.

Application of MI to Groups

Velasquez, M.M., Stephens, N.S., & Ingersoll, K. (2009). Motivational interviewing in groups. Journal of Groups in Addiction and Recovery. 1(1) 27-50.

Any approach to facilitating change can be adapted to working in groups. The advantages of working in groups include:

- Cost effective and efficient.
- Groups provide a safe opportunity to remediate interpersonal deficits in communication.
- Peer feedback and modeling may have more impact on individuals than the counselor generated information.
- Interactions with peers may hep members generalize their new change efforts to the real world.
- Realization that other share similar problems.
- Groups provide a meaningful social support system.

For us to use MI effectively in groups we need to focus on how to facilitate group process to address the four Key Principles of MI. These present both challenges and opportunities.

Express Empathy

Challenges - Individuals within the group may be at different stages of change and ability to express empathy for someone's struggles.

Opportunities -Roll modeling by group members will reinforce the fact that one can be in any stage of change and still understand the perspective of others.

Develop Discrepancy

Challenge - Identifying discrepancies between where someone is now and where they want to be can have a confrontational quality to it. If this feedback comes across as criticizing or "putting down" the impact will be less effective.

Opportunities - Learning how to confront (and receive confrontation) is a key interpersonal skill. The group can facilitate learning these social skills.

Roll with Resistance

Challenges - Again the relative sophistication of the group and their interpersonal skill level can provide some challenges. Some may feel that the ONE WAY they took to recovery is the ONLY WAY.

Opportunities - Through the expression of numerous paths to recovery the group members can develop an appreciation for

diversity in treatment and recovery and move away from dogmatic, one way practices.

Support Self-Efficacy

Challenges - Some groups can foster dependence on the group itself. While groups provide a very useful scaffold for self-efficacy, many can become overly dependent on the group to support their recovery.

Opportunities - There is a great opportunity to have the group define dependence and inter-dependence as it relates to the role of the group in each of their lives.

Family Theory

Although we sometimes don't think about them this way, the "family" is the most common of all the groups! Much of what we have learned about groups so far in this chapter also applies to families. But, families have unique dynamics that set them apart and require special care and consideration when engaging in Motivational Interviewing.

One of the most well documented theories of how families operate was created by Dr. Murray Bowen. Visit the Bowen Center for the Study of Family for a full explanation of this model.

THE BOWEN CENTER
for the Study of the Family
DEDICATED TO THE DEVELOPMENT AND DISSEMINATION OF BOWEN THEORY

The Bowen Family Systems Theory

What follows is a brief overview of this model. Reading the documents directly from the Bowen Center is a much better preparation for the study of Family Systems.

Basic Theory

This theory views the family as a single emotional unit and uses system thinking to understand the complex interactions among members of the family. The emotional bonds that exist among family members strengthens the cohesion of the group and supports the family's functions to protect, support, and provide identity for each member.

Increased stress or anxiety among family members can have an added cohesion effect, bringing the members closer together. However, as these emotions intensify, family members can become more stressful than comforting. At times, this can result in one or more members taking added responsibility for the emotional welfare of another family member. Individuals

can give up personal responsibility for their behaviors and others can become overwhelmed and “burned-out”.

Eight Concepts

Bowen’s theory is made up of 8 concepts. These concepts are briefly reviewed below, so be sure to check the Bowen Center website for a more thorough discussion of each of them.

Triangles

A triangle is a three-person relationship system. While a two-person system cannot tolerate a lot of tension, a three-person system can. The stabilizing impact of a three-person system can maintain the structure, but the issues do not get resolved.

Differentiation of Self

Groups, including families, can have a tremendous impact on how we think, feel, and act. The less developed a person’s “self” is, the more impact the group has on their thinking. These individuals depend heavily on the opinion of others to form self concepts (view this great KhanAcademy video on the Looking Glass Self Theory by Charles Horton Cooley for a great focus on this particular aspect of social-psychology!)

Differentiation of self is a natural process of human development. Some families can act in ways to inhibit members to differentiate and this can become problematic.

Nuclear Family and Emotional Process

This concept identifies four basic relationship patterns that describe where family problems come from:

- Marital Conflict
- Dysfunction in one Spouse
- Impairment of one or more Children
- Emotional Distance

Family Projection Process

This identifies when parents project their own emotional problems onto their children. Children learn a lot of very functional behaviors from their parents. However, they can also inherit some problems. These may include:

- Heightened need for attention and approval
- Difficulty dealing with expectations
- Tendency to blame oneself or others
- Feeling responsible for the happiness of others or that others are responsible for their happiness
- Acting impulsively to relieve anxiety

Parents may project their own problems (listed above) onto their kids, the kids respond by a self-fulfilling prophecy process, and then the focus is on the dysfunction in the kids.

Multigenerational Transmission Process

This concept focuses on the development of differentiation of self on a generational basis. When a nuclear family has a number of children, it is likely that one will develop a more refined concept of "self" and the others will be less developed. When this person with the higher developed self marries, they are likely to find a person with an equally high developed sense of self, and thus the two are more differentiated from family.

Over time you may have some members of the family who are highly differentiated, often disconnected, from the family, as these differences intensify over successive generations.

Emotional Cutoff

This concept describes the process of when a family member manages their unresolved emotional issues by cutting off emotional contact with the family. While this may be adaptive, the person runs the risk that while their cut off from the family reduces the tension in the family, they make their new relationships more important. These other relationships may be with spouses and other families, but they may also form within social and work relationships.

Sibling Position

Bowen found the work on sibling position by Walter Toman so consistent with his own ideas, he incorporated it into his theory.

Walter Toman's seminal work Family Constellation is available for free download as an ePub document (this will open in iBooks) and describes his theory of birth order impacts.

Societal Emotional Processes

Bowen describes that each of the concepts outlined in his theory are also applicable to groups outside the family. Similar processes can be identified in work, groups of friends, and even larger social structures such as corporations, government organizations, and politics.

Applications to MI

Having a deep understanding of these processes and how they can occur in groups (including families) provides practitioners with tools to identify specific behaviors (and their underlying causes.)

These concepts allow you to express empathy and understand the underlying causes of someone's behavior. They also allow you to identify discrepancies between what a persons says they want and their behavior. Teaching your clients about these concepts allows you to better understand resistance to them from

these same clients. Finally, the concepts allow you to support self-efficacy among family members, and the single emotional unit of the family, to work on these specific issues and problems.

At times, simply being aware of the construction of the issue and its mechanism can be a catalyst for change in a group or family. Knowing that what they are going through has been experienced by others can be a very comforting feeling.

Assessment

Chapter 8 Discussion

Review the details of the Challenges and Opportunities of MI in groups and read the Velasquez, et. al. (2009) article. Reflect on the pros and cons of working in groups, your own personal experience (if any) in groups, and what challenges you may have facilitating such a group.

Chapter 8 Assignment

Family Diagram

For this assignment you are going to apply the basic concepts of the Bowen Family Systems Theory. The family that you choose to "analyze" can be your own or another, but it has to be a real family.

Also, although this information could be of value to the family, I'm going to ask that you choose to not share it with them unless you feel this is a safe and effective way for the family to move through a problem. This is an easy model to understand but it is a difficult model to bring into a family without a trained therapist to help.

Part I: Family Diagram

The first part of this assignment is to design a chart that describes your family and the relationships among members. Your chart should have an icon for each member (as many as you want to include), lines connecting them to identify "parents", "siblings", and other types of relationships.

You should also identify any of the Concepts from the Bowen Family System Theory that exist in your family.

This part of the assignment is somewhat creative. Be sure that you use colors, shapes, and text to fully describe your family system. Include in the chart whatever information you feel would be relevant to include.

To complete this part of the assignment you are going to use an app called Lucidchart.

Text Link

To learn how to use Lucidchart, click below to look p the app in the iOS and App Tutorial CourseBook

Text Link

Part II: Intervention and Submission

Export your completed chart from Lucidchart into your photos app. Open up your word process, create a title page, on the second page insert a copy of your chart.

Finally, on the third page, write a specific description of a particular problem that one of your family members has. Link this to specific concepts and terms from the Bowen theory.

Next, write a brief analysis as to how you might engage this person in a Motivational Interviewing session. Describe how you might invite this person to talk about the problem, describe how you would explain the applied concept from the theory, and identify what might happen in each specific part of the MI process that could benefit or hinder the resolution of this problem.

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Grading Rubric for Chapter 8 Assignment

Emotions and Motivation

9

Attention

Emotions as Motivations

Helping our clients get in touch with, and understand their emotions is a primary function of the counseling process!

Emotions and motivation are deeply connected both etiologically (they come from the same root word) and pragmatically (emotions are the primary energy behind motivating action.)

This Chapter will explore the interaction of emotions, motivation, and the impact of trauma (a common experience among our clients) on this interaction.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Demonstrate the ability to identify the emotions a person may be experiencing.
2. Describe why an exploration of feelings is important in the counseling process.
3. Describe the prevalence, screening and assessment, and stages of recovery of persons who have experienced trauma.

Teaching

Feelings...

It seems to be the catch term in counseling..."How do you feel about that?"

Why such the emphasis on "feelings"? I'll give you a hint...consider the word "Emotion"...look at the roots of the word..."Motion", "Motive", "Motivation"...so what makes us MOVE???

Getting to Feelings

We want to assist our clients in getting to know their emotional world. By understanding their emotional world they can understand the forces that motivate them and un-motivate them to take action to bring about change.

Often emotions are conflicted as well...they might be feeling more than one feeling at the same time about the same thing!! This can feel "crazy" and scary.

Approaching Feelings

We approach feelings with the same tentative care that we approached Paraphrasing...we want to be sure that we are on the same page as our clients so when we attempt to identify the feelings we want to check to see if we are right.

If we see, for instance, a discrepancy between what someone is SAYING that they feel, and their ACTIONS or EXPRESSIONS we want to explore this carefully.

Why we DON'T want to explore Feelings

It is scary to open these "cans of worms". Sometimes we want to steer away from the expressions not to suppress them but to ensure that the person has enough supports should all these feelings come tumbling out! It is irresponsible to open up all these wounds and them simply walk away...session done!

So we are careful...like a rhino in a china store with boxing gloves on...go slow, carefully, and try not to break anything!

Reflection of Feelings

Since our clients' are often emotionally conflicted (meaning, they may feel multiple, seemingly incompatible ways about something...such as both "relief" and "sad" when someone has died.) it helps for us to simply identify the emotions that we are picking up on in our clients. The same way we use "reflection" to simply identify and repeat what someone has said, we use "reflection of emotion" to simply identify the emotions they seem to be having.

Just as in other types of reflection, we want to do a check to be sure we are correct. Sometimes we are not. We may identify that the person is feeling "sad" when they are not...they will tell you if you are wrong! That is one of the great dynamics of working in this field.

Reflecting Feelings

Text Link

Feelings and Motivation

Motivation

When we are working with an individual through the MI process, we often have to help clients find a reason to go through the process of change. Change, as we have already discussed, can take a lot of energy and persistence so the person undergoing the “work” of change needs to really want it!

This really is where an exploration of emotions comes into place. Finding the emotional base of what is going on is going to be key to understanding your client’s motivation. Emotions are what MOVE us to action!

Feeling vs. Thinking

When we ask someone how they feel about something they may often avoid the actual feeling about something and refer to how they are thinking about it. We can all think about a situation, and we may come to logical conclusions as to how to make change, but the THINKING is not going to be a source of energy for this effort.

When searching for the energy someone needs to make change we will find that energy in the emotional world of that person. It is often not enough that a person wants a job in order to pay bills...it may be that underneath all of that is a deeper

sense of disappointment and sadness in their “failure” to have a job. These emotions, sadness and fear and anger, can be sources of energy that get the individual to actually take action.

We often miss this point and simply approach planning “logically”. Exploring the real feelings someone is having about a situation can be a bit scary at first. We are going into places that may trigger our own emotional reactions related to fear, anger, frustration, and sadness.

A great measure of our ability to engage in conversations about and deal with our own and others’ emotions and emotional states is our Emotional Intelligence.

Emotional Intelligence

Emotional Intelligence is a measure of our ability to manage our own and others' emotions. Research in this field has indicated that Emotional Intelligence can be as important as IQ in predicting success.

Click HERE to read an article on the importance of Emotional Intelligence

Click HERE to visit a website on Emotional Intelligence...there are MANY of them!

Click HERE to visit a website and take an Emotional Intelligence test!

Trauma

A large part of our emotional make-up has to do with our relationship with the world. By this, I mean the ways in which we perceive the world, its consistencies and inconsistencies, our role in the world, our sense of the world being a safe place, and our willingness to engage with other people in it.

The experience of trauma can have a tremendous impact on a person’s relationship and trust in the world. Sadly, many of our clients have experienced some sort of trauma through their lives. Even if simply look at the experience of acquiring a mental illness, that is trauma enough. So, once can say, that every client that we deal with has to deal with some level of traumatic experience.

What causes Trauma?

Well, it might be silly to say it, but “traumatic experiences” cause trauma! Different people will experience events in their lives and some of these will be inherently traumatic (rape, death of a person, accidents), others have to do with our inner experiences of a situation (verbal assault, losing a job, a relationship break-up), while others may be vicariously or indirectly experienced (911, witnessing war on TV).

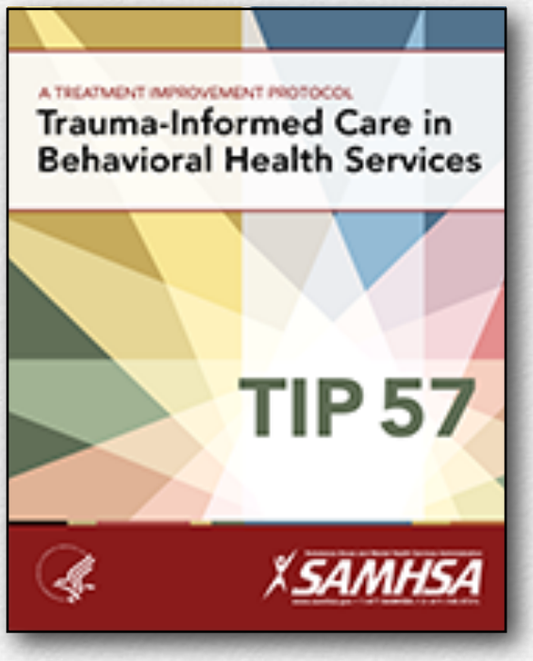
The best way to understand trauma is to look at how it impacts a person.

Impact of Trauma

Some individuals who experience a traumatic event may develop a series anxiety disorder or PTSD (Post Traumatic Stress Disorder). Some may develop ongoing problems with relationships and self-concept/self-esteem.

Trauma is such a pervasive and important aspect of the lives of many of our clients it is worthwhile to spend a great deal of time coming to a deep understanding of the impact of trauma on lives.

SAMHSA has published a very informative resources on trauma called Trauma-Informed Care in Behavioral Health Services.



Select the image above to download this PDF

What to look for in Tip 57

Some of the areas that are of particular interest related to this Chapter include the following:

- What is Trauma?
- Types of Trauma
- Sequences of Trauma Reactions
- Common Experience and Responses to Trauma
- Screening and Assessment
- Trauma-Informed Prevention and Treatment Objectives

Assessment

Chapter 9 Discussion A

Talking about feelings is often confused with talking about what someone "thinks" about something. Feelings are raw and volatile (meaning subject to change). We tend to stay in the "head" and not make it down to the "heart". Describe two different situations in which you might be reluctant to actually talk about the feelings that someone is having. Is it hard for you to talk about fear, or dread, or depression? What about anger?

Report on the results of your Emotional Intelligence test. How do you think this reflects in your actions and comfort level in dealing with emotionally charged situations?

How “good” do you think you are on identifying the emotions of someone else? Reflect on the EVIDENCE you may have where individuals have actually agreed that you understand this stuff.

Chapter 9 Discussion B

Review the contents of Trauma-Informed Care in Behavioral Health Services. Share your discoveries related to the impact and prevalence of trauma, the screening tools that we may use, and how we may modify our practice in light of this information.

Confrontation

10

Attention

Changing someone’s mind...

Sometimes we don't agree with the person we are interviewing or counseling. While we have nurtured a sense of multicultural awareness and alternative points of view, we might still want to "change someone's mind" about something when they are seeing things from a particular point of view or their thoughts are irrational.

Picking how and when to do this are key questions for the counselor. It is somewhat of a test of how good a relationship you have developed up until now!

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Identify personal "problem solving" and "conflict avoiding" styles of interaction
2. Reflect on the role that your personal style may play in your own efforts to confront your clients
3. Reflect on your personality type and personal experiences regarding confrontation

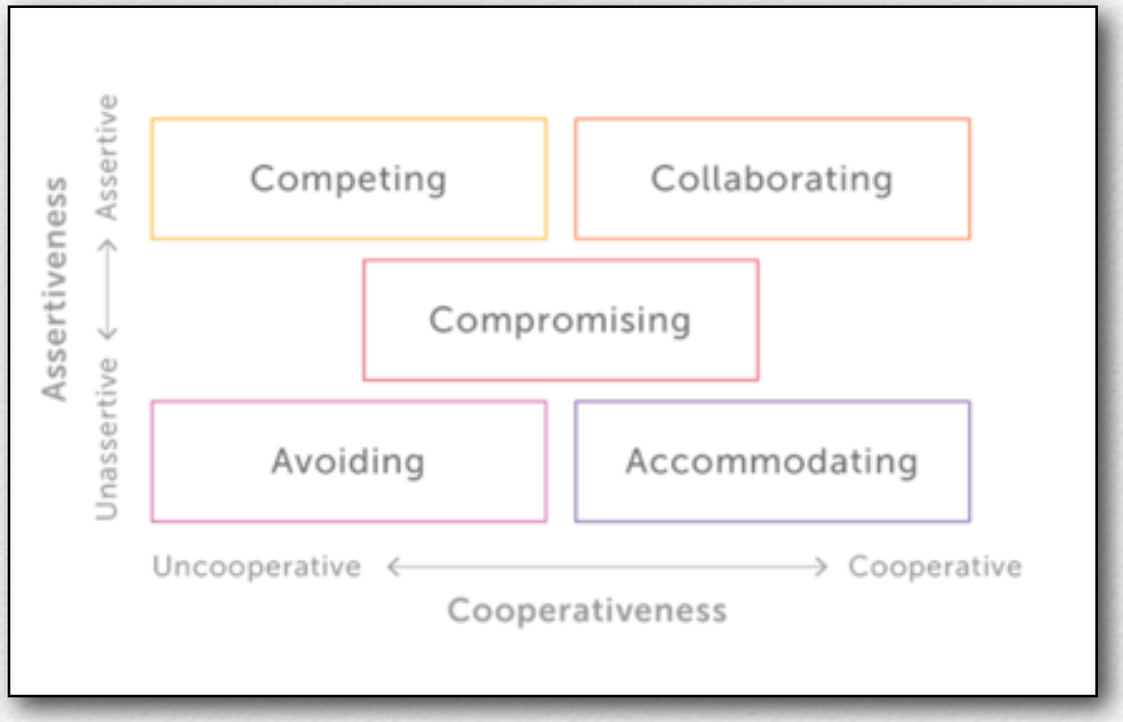
Teaching

Confrontation

Confrontation is one of the most difficult skills for the same reason it is hard to reflect feeling...we are not used to dealing with feelings and many of nurture a pretty good habit of AVOIDING conflict. In confrontation, you are taking the risk that conflict might arise.

Styles of Confrontation

The most widely understood model for Styles of Confrontation is the Thomas-Kilmann Conflict Mode Instrument (TKI). This particular model focuses on the dimensions of the "importance of the issue - assertiveness" and the "importance of the relationship - cooperativeness" This next graphic represents the basic styles of each of the four quadrants..."Compromising Style" is a combination of all of them.



VIDEO Thomas-Killman Conflict Model

Text Link

For now the actual Thomas-Kilmann Instrument for measuring your style is only available at a cost. Some self-reflection, however, might shed light on instances in which you have exercised each of these approaches to conflict resolution and may even identity your preferred style...good or bad!

Click HERE to read a really great article by Kilmann on Celebrating 40 Years with the TKI Assessment

The Myers-Briggs Option

Another, and more accessible tool, for developing introspection into your confrontational style is the Myers-Briggs Type Inventory (MBTI).

Click HERE to read a great little article written about how certain personality characteristics identified by the MBTI can lead to conflict and how to address each others needs from different points of view!

In the Assessment section of this Chapter you will be using an app to determine your MBTI type and apply it to personal conflict management.

Confrontation in the Helping Profession

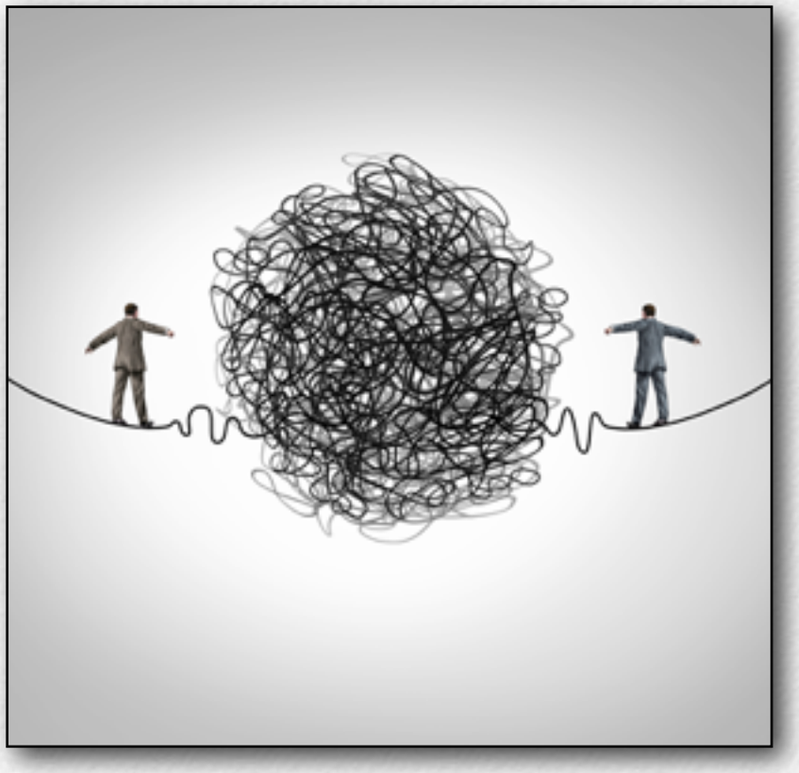
So, what role could confrontation have in the helping profession or in Motivational Interviewing. The first thing to keep in mind is that confrontation is not a “fight”, it may not even be emotionally charged or difficult. It is, however, a common occurrence in the field.

Confrontation is a skill that we use when we feel it is necessary to point out a discrepancy between what someone says and what someone is doing. This can be done in a very supportive and understanding way, taking into account our knowledge of our clients Stage of Change and other developmental factors. Remember...change can be very challenging, even when it is for the over all good. In addition, old habits die hard! Breaking out of older modes of behavior may take some time.

When we are working with clients there are many opportunities or situations we may encounter that necessitate a confrontation acton on our part. Our goal is to be the honest person that points out to others when they are not being honest with themselves, or when they behave in ways that are contrary to their goals or to the self they want to be.

In truth, confrontation can be a very positive experience. It can be when we call someone out on something, but we do it in a supportive and caring way. We may be the only person in their lives who is that honest with them!

Opportunities for Confrontation



The following is a list of different circumstances that may elicit some confrontation on our part:

Immobility

Immobility refers to a person's sense of powerlessness to act in a certain way. We may need to remind our clients of emotional connection they have to the goal and support them in the risk taking action of these first steps.

Blocks

Somewhat related to the work of Albert Ellis and his Rational-Emotive Therapy (RET)Model. Blocks are internal statements that we live by that either limit our options for behavior. From the point of RET these can be described as irrational beliefs that the person has. Examples of irrational thoughts include the following:

- I'll never be able to work.
- People don't like me and never will.
- Persons with mental illness cannot get a job.
- I'm not smart enough to go to school

Repetitive compulsions

This type of opportunity can occur when we identify that the individual continues to engage in problematic behavior. Individuals who continue to go to a bar when they are trying to quit drinking may be engaging in Repetitive compulsive behavior placing themselves at risk for relapse.

Inability to achieve goals

Sometimes we may not be sure what is happening, but the individual may simply not be doing what it takes to achieve their

goals. We may want to question if the person is really committed to that goal.

Lack of understanding

This is an educational confrontation. We may educate a person on “how the world really works”. Sometimes our clients have irrational beliefs about the world. This is not the same as the instances of delusions, but can be just as irrational.

Limited behavioral repertoire

As it states, we may confront someone because they are either choosing or lack additional behavioral responses to the situation they are in. Our confrontation takes the form of offering to assist with and teach the person additional ways in which they can respond to situations.

Limited life script

We may encounter this in a person who has accepted a relatively low degree of achievement in their own lives. Through learned helplessness, the client may have simply concluded that certain things in life can never be attained, so why try?

Impasse

An impasse is a point at which you come to a disagreement about a situation with your client. This may arise from any aspect of the relationship from payment for services, refusal to participate in the change process, rude and inconsiderate behavior, and criminal and other value-conflicting behaviors. This is the “agree to disagree” point and may serve as a turning point in the relationship, or it may result in the termination of services.

Lack of motivation

Assuming that you have already gone through the process of Motivational Interviewing, you may have to revisit the client’s commitment to the work of the plan. Reconnecting a client to their larger goals is a good confrontational process.

Steps in Confrontation

We often know when we are in a situation in which a confrontation is called for. There can be a great deal of tension and/or difficulty in communication. Here is where our conflict resolution style comes into play...when we sense this, we have a tendency to resort to our preferred style.

When dealing with a confrontation opportunity with clients we want to:

- Identify the conflict - call it what it is...we are not ones to let it go unnoticed.
- Point out the issue - as best you can, identify the problem behaviors that have led to the confrontation. Be open to the client's view of the situation and the potential for misunderstanding.
- Evaluate the change - evaluate the client's willingness to engage in dialogue and change. Self-evaluate your own role in the conflict.

Assessment

Chapter 10 Discussion

Review the conflict resolution models and find how you personally deal with conflict. Conflict in the counseling process can be emotional and thus we might avoid it the same we discussed how we avoid discussing feelings. Describe any situation you have experienced where you chose not to confront someone even though you would have liked to. Discuss how do you feel that your confrontation/conflict resolution style may positively and/or negatively impact your work with clients.

Chapter 10 Assignment

Personality and Conflict

For this assignment I would like you to reflect upon the Myers-Briggs tests results that you will get by using the app titled “Jungian Type Questionnaire”.

Click the app icon below to get this app!

Text Link

This app ($.99) provides a way to take the test, get your letter combination and then some additional information on the interpretation of the results.

Text Link

A FREE alternative to this app can be found at the link below.

Jung Typology Test

There are literally thousands of websites on how to use these scores.

To assist in your personal interpretation of your Myers-Briggs Typology Test...visit TypeLogic

Five Tips for using the Using the MBTI in Conflict

Using the Myers-Briggs Type Indicator to Enhance Workplace Communication

Part I - Report the actual results and review the "Five Tips" and "Workplace Communication" websites.

Reflect on what you have learned about yourself through this process. It is important that you use the terms and concepts from these sources to complete this assignment.

Specifically, visit the website below and read up on the relationship between your personality type and conflict management style. Does this article describe your processes well? How might you communicate this to others in the workplace?

Use of the Myers-Briggs Conflict Pairs in Assessing Conflict

Part II - Select a significant other person in your life and have them complete the same test using the app. Using this website (again), identify potential conflicting letter pairs. Use this information to engage in a discussion about conflict and conflict resolution in your own relationship. Report a summary of the results of the test, the individual pairs of letters, and the conversation. (Select a person who is going to be OPEN to this conversation.)

Write up this document, with a title page, and submit it to the appropriate drop box.

Grading Rubric for Chapter 10 Assignment

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Termination

11

Attention

Endings and Loss

Often the relationships we forge with our clients have been intense and not without some challenges. Over time an emotional bond can emerge between client and staff. In most circumstances, our work needs to come to an end at one point and we need to terminate services. The relationships we have with our clients are supposed to be transitional, and our hope is that the skills we have helped them acquire will assist them in developing close social connections outside of the mental health field.

We need to be intentional about how we approach ending these relationships.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Define what termination of a counseling relationship means
2. Explore examples and implications of termination
3. Identify the components of a termination letter

Teaching

Counseling Termination

Every time you begin a new professional relationship with a consumer you should always be thinking about how you will begin your work with that person, what you will do during your time together and how you will determine when you will terminate (end) your relationship with that consumer. The act of closing a case results in you having to say good-bye to the consumer. This is the act of termination. Termination generally occurs when all of the consumer's goals for the mental health service have been met. For example, the person needed stable housing and now they are in stable housing. As you work with a consumer you would be reviewing the goals of your work together (on the treatment plan) and informing him/her on a regular basis of what has been accomplished and what is remaining. A worker should be discussing the idea of termination during their first or second visit with a consumer. That helps to set the stage of what the tasks and goals are toward improving the consumer's situation. Once the situation is improved then that should be celebrated and termination can be considered part of that process. As with any interaction it is all in how you frame the conversations. It should be a positive step that someone accomplished their goals and a specific mental health service is no longer needed. Consumers can perceive termination as a punishment for success and grieve the loss of the relationship with a mental health worker.

Read about Moving Toward Termination of Therapy by following this link:

There are times that a consumer drives the termination of a case. For example, if the consumer has just stopped showing up, responding to calls and has not been home then you may be planning a termination without seeing the consumer again. This can be hard for the worker since you will not have the opportunity to talk to the consumer and say good-bye. Another consumer driven situation is if the consumer "fires you" from their care. Sometimes consumers have expectations of a worker that may or may not be accurate. If they feel the worker is not meeting their expectations, they may ask to have their case transferred or closed. This situation would also result in the termination of a worker - consumer relationship.

The idea of losing a service provider can be very stressful for consumers. It is up to the mental health professional to help the

consumer work through any stress or anxiety the plan for termination can create. It is time for you to use all of your professional skills to praise the consumer for progress, reinforce how far he/she has come and what positive things lie ahead in the future.

It doesn't matter if you are a crisis worker who is only working with the person for 48 hours or a staff member in a residential facility where people live for years. Each time you develop a professional relationship with a consumer it is considered a therapeutic relationship. When the consumer leaves the service or you leave that role, or that agency, this creates a termination in that relationship. One of the biggest reasons for termination in the field of mental health care is the departure of a staff member from one role or agency to another. The following article provides insights into termination when driven by staff change, not consumer choice.

Writing a Termination Letter

On occasion you may need to write a letter to your client expressing that services are terminating. Termination can come about for a number of reasons.

- The work and goals that you set out to do are complete.
- The client no longer wants to receive services.
- The client has engaged in behavior that makes the ineligible for continuing services.
- Funding for services has come to an end.

The best way for services to come to a close is by mutual consent, when the goals have been met and you have effectively "worked yourself out of a job". Ideally, there would be an opportunity to meet with your client and discuss termination and go over all the issues related to ending services.

Contents of the Termination Letter

At the end of services you want to clearly outline the following issues (again, ideally, you would have had the opportunity to discuss these topics face-to-face with a follow-up letter):

- A statement that informs the client what termination of treatment is and that emphasizes that it is the client's responsibility to personally seek further treatment if appropriate.
- Include your client's name (no "Dear Client" form letters).
- Identify the date when therapy began.
- Note the termination date.
- Relate the primary and secondary diagnosis or, if no diagnosis was give, relate the primary cause for treatment.

- Describe the reason for termination.
- Summarize treatment, including any need for additional services.
- If you feel further treatment is advisable or necessary, make that explicit in your letter.
- List three or more referrals or referral sources, including addresses and phone numbers.
- Discuss any boundary related issues such as how each of you can behave if you run into each other once services have ended (this may have been discussed earlier in your work.)

http://tamarasuttle.com/what-does-a-psychotherapists-termination-letter-include/

Assessment

Chapter 11 Discussion

Share a story from your life of when you had to terminate a relationship (personal or professional). Share what you learned from that experience, and the readings above, about how you might approach the idea of termination of a relationship in the future.

Self-Care

12

Attention

Burnout

Check out this article:

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in Mental Health Services: A Review of the Problem and Its Remediation. Administration and Policy in Mental Health, 39(5), 341–352.

Burnout is described by the APA as a state of chronic stress that leads to:

- Physical and emotional exhaustion
- Cynicism and detachment
- Feelings of ineffectiveness and lack of accomplishment

Stress may be a contributing factor to burnout, but it is not the only one. There are many work factors that contribute to the high rate of burnout in the mental health field.

These include:

- Lack of control
- Values conflict
- Insufficient rewards
- Work overload
- Unfairness
- Breakdown of community

In this Chapter we will examine burnout and balance!

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Define self care and its potential value to the professional success of a mental health worker
2. Explore examples in your own life of the importance of self care
3. Demonstrate the ability to identify one or more self care activities

Teaching

The Mental Health Workplace

When you work in the field of mental health you spend your days helping others to improve their lives, overcome barriers and find success in the little things. This work has times when it can be discouraging or frustrating.

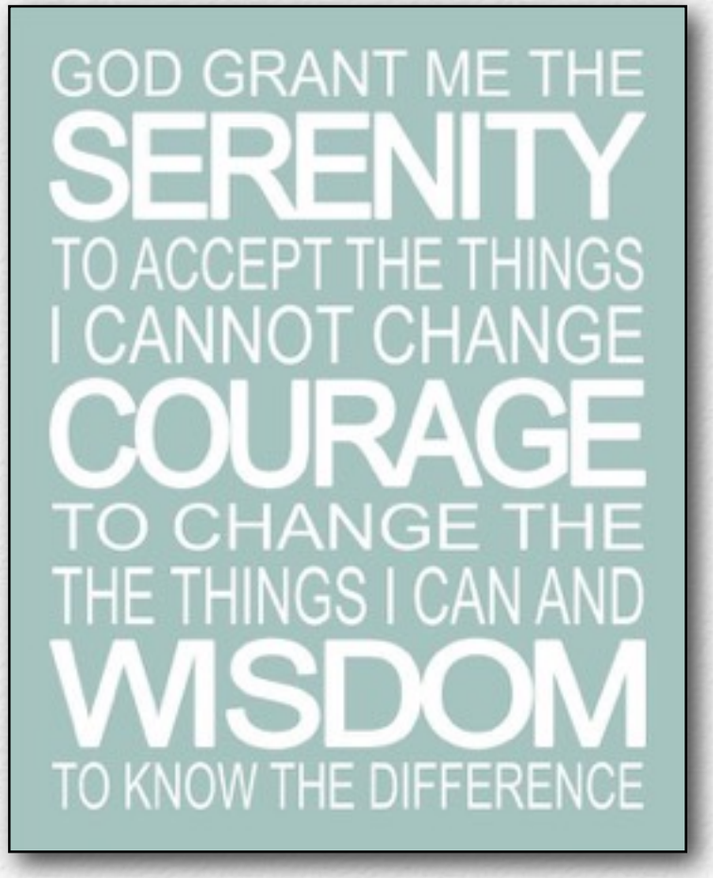
In addition, the field of mental health largely embodies the six work factors identified as leading to burnout.

- Lack of control
- Values conflict
- Insufficient rewards
- Work overload
- Unfairness
- Breakdown of community

Knowledgeable of the nature of the field you are going into, you need to develop some strategies for self-care that will allow you to continue to be an effective helper for this highly vulnerable population.

Control

One of the most important aspects of workplace self-care is to recognize the difference between things that are in your control and things that are not in your control. And, this can change.



Changes will occur over the time you are in the field. Your job duties may change, what you can and cannot do may change, your employer may change, etc. Much of this is out of your control so it is important to focus on the areas that are in your control. WHO you work for (or even if you work in this field at all) is in YOUR control.

Your attitude and approach to change is also in your control. You control your own behavior (and you DO NOT control the behavior of others...don't we wish we could!)

Keeping to the Serenity Prayer is a key skill to develop to avoid burnout.

Values

Throughout this course we have talked about values and diversity. You will find differences between you and your clients in regard to values. However, you will also find differences in your values and those of your workplace, co-workers, and supervisors. You may find that not all individuals in the mental health field share your passion, your desire to empower, or your genuine affection for your clients.

"Values Clarification" is the process by which you take stock of the values you hold to be true and meaningful. These are the "lines in the sand" that you can draw to ensure that you do not act outside of your own personal values.

Insufficient Rewards

If you came into this field to get rich...well, you took a wrong turn! Despite the very high skill level required for this work, it is generally low paying in relation to other allied health professions.

While money is very important, it is not the only source of rewards in this work. Personal satisfaction in your work, self-determined time-management, "not stuck in an office", meeting interesting people, etc. These are all very tangible sources of reward for our kind of work.

As part of self-care, it is important to seek out rewards of all kinds from your employer. Getting feedback on your good work, taking on responsibilities, sharing your ideas, getting

praise, etc. These are all sources of reward that will compensate for the relatively low salary (a bit!)

Work Overload

This one is increasingly becoming problematic. It is not that we did not have work overload before, it is just very challenging now as the work can sometimes be directly connected to your pay.

It is hard to tell how many clients someone should have on their caseload at any given time. We know that we can likely handle a lot, but all it takes is one crisis situation to wreck your plans for the day and set you behind in your work.

In these circumstances, you need to refer to the section on Control!

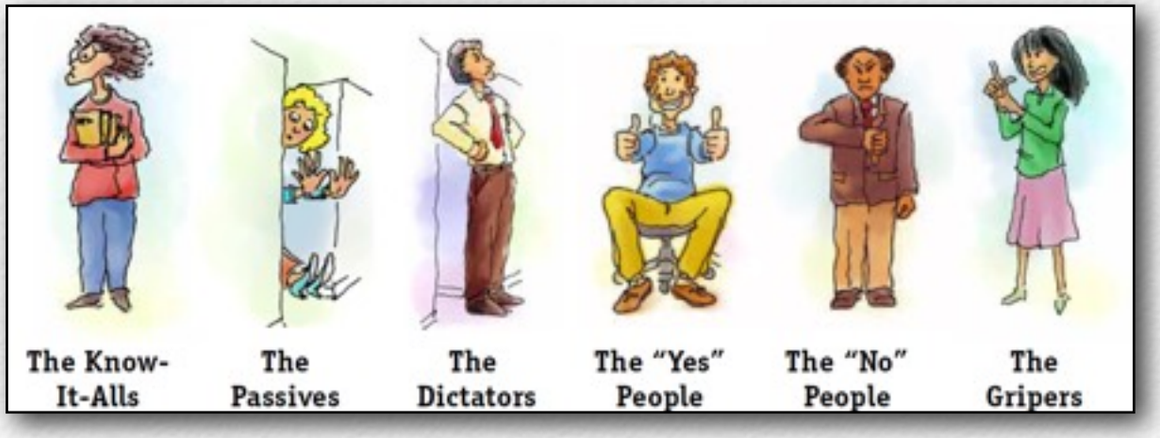
For personal self-care, it is important to discuss work load, time management, and productivity in supervision. Others can share their tips for a more efficient work process and management should be open to creative changes in workflow that can bring this about.

Unfairness

Things do not always go as they “should”. Sometimes the person who does not deserve a promotion gets one, sometimes we are blamed for problems that are not our fault, and sometimes we encounter loss, pain, frustration, and despair and it seems to not matter much to others.

It is very important to remember the “human” part of “human services”! Even though we are in the helping profession, there are still people in the field that can be difficult to work with.

The most important strategy for dealing with difficult people in the workplace is to make sure your are not one of them!



We are advocates. We teach our clients to advocate for themselves and we have to be able to live up to this ourselves. There comes a time when we need to point out when things are unfair. We need to do this, however, using all the confrontation skills we have already learned about! Our goal is to resolve the situation and build/improve the relationships at work.

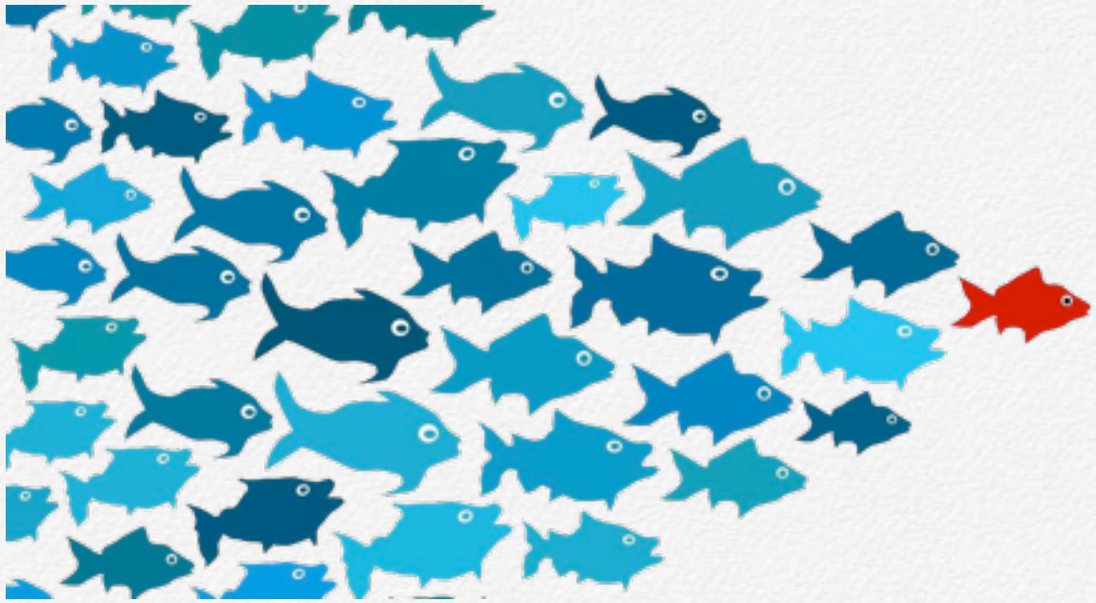
The incidence of true work conflict, resolved only with legal grievances, are rare.

Breakdown of Community

Community can be defined as the sense of connectedness you feel with your coworkers and your workplace. The very things that draw us to this field, create a lot of the connectedness that we feel with like-minded people.

It is not necessary to become friends with all of your coworkers in order to have community. The shared experience of working together, collaboration, shared values and goals, and a shared vision, go a long way to ensure these connections.

Executive leadership can be instrumental in creating community...they can also be instrumental in destroying it.



When community breaks down it breeds mistrust, gossip, rumors, back-stabbing, and general inefficiency. These can be detrimental to an organization.

Actively seek out those who think as you do. Avoid the temptation to jump on the “bandwagon” of rumors and gossip in the workplace. Ignoring these sources of negativity will not set you back in your work, but distinguish you as a person who does not stoop to that level.

Find connections at work where you can vent your true thoughts about things. There are always issues at work, sometimes serious ones. You want to find a person at work you can trust who will understand the situation and allow you to talk about them.

Balance

This is a word that you will probably grow tired of hearing!

Balance

This refers to our ability to lead lives that exemplify a balance between work and enjoyment. Even if we love our work, we need to take time away from it to refresh our creativity and increase our productivity.

Be mindful that a quick break on your computer to your favorite shopping website will NOT do it. There is pretty substantial evidence that this kind of break is not a break at all.

Home is you Haven

Throughout your day you will encounter troubles and challenges in people's lives. You endeavor to be the calm rudder of stability in problem solving and conflict resolution. If you then go home to personal chaos, disruption, conflict, and struggles on a daily basis, you are a very likely candidate for burnout.

The conflict here is that the very skills that attract you to this field may also attract you to people in your life who are equally in need of you (like your clients). If you have chosen to have a less than tranquil home (or it is being thrust upon you), you have the opportunity to make choices and changes.

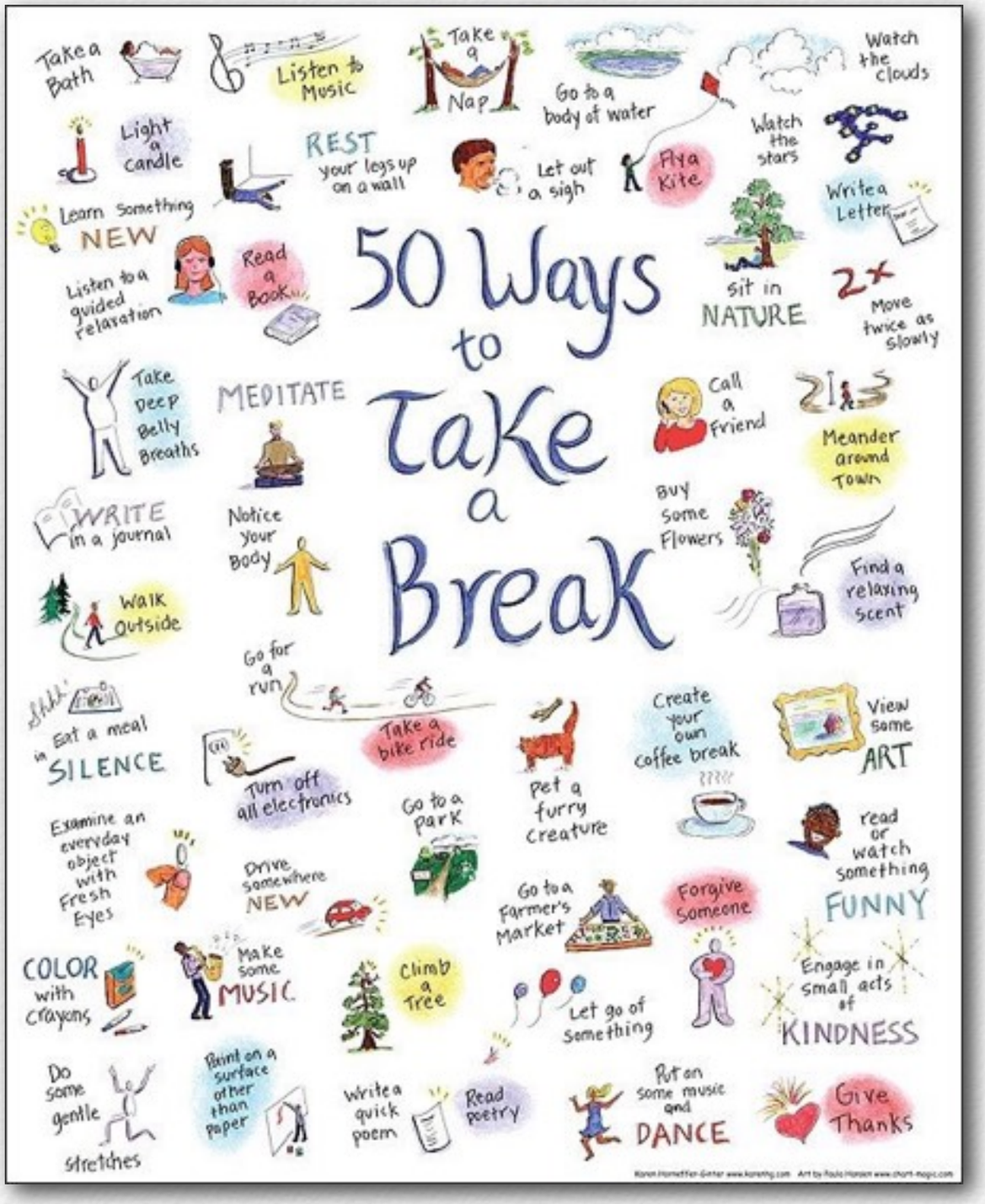
My advice is that you choose to have a peaceful home. This may necessitate some changes in your home, sign delegation or responsibilities, the development of better communication skills, better financial management skills, more shared family time, and personal (alone) space and time (in this regard it may be good to have a place you can go when you need a "time out"!)

Rest and Relaxation

Our work needs to be very creative. The nurturing of a creative mind is one that is diverse in interests and activities. To engage in self-care you will want to nurture non-work-related activities and recreation that you can become passionate about.

The graphic on the following page provides a really good list of all the different kinds of mind-resting/engaging activities we can choose to do.

Hobbies, athletics, the arts, sports, etc. These are all very good and healthy activities related to self care.



Please review all the sections of the following learning module on Self Care created by Syracuse University's School of Education.

Within this learning module, pay special attention to the following sub-modules:

Essential Information

- The Dimensions of Self-care
- Stress
- Stress prevention and intervention through self-care

Assessment

Chapter 12 Discussion

Share your stress management, anti-burn out plan. If you don't have one, there is no better time than now to create one!

Perhaps there are others in this class who would love a crafting partner or a work out buddy!

Chapter 12 Assignment

Write a brief paper (title page, paper, and references) on how does the American Counseling Association's Code of Ethics apply to the issue of self-care as discussed in this lesson and through the links provided?

Do you think your current self care practices would place you in compliance with the Code of Ethics sections C.2. Professional Competence and A.1. Termination and Referral? Please explain you answer.

Submit this assignment in the appropriate drop box.

Grading Rubric for Chapter 12 Assignment

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Signature Assignments

13

Signature Assignments

Signature Assignments and General Education Learning Outcomes

This section of the CourseBook provides guides and instructions for the completion of a set of assignments referred to collectively as “Signature Assignments.”

According to the Association of American Colleges and Universities:

Signature assignments require students to demonstrate and apply their proficiency in one or more key learning outcomes. This often means synthesizing, analyzing, and applying cumulative knowledge and skills through problem- or inquiry-based assignments or projects. Signature assignments may also follow a theme across curricular and co-curricular experiences tied to the institutional mission or features of the surrounding community, allowing students to apply their growing knowledge and abilities to meaningful questions over time. At some institutions, all signature assignments must include specific components, such as a “real-world” application, reflective writing, or collaborative work.

The most distinctive feature of signature assignments is the way programs integrate them across the educational pathway to help students demonstrate their growth, make connections across the curriculum and co-curriculum, and apply their knowledge to real world problems.

AAC&U, Retrieved June 14, 2017

Association of American Colleges and Universities

The AAC&U has defined what it feels is essential knowledge and skills for undergraduate education and defines them through their VALUE Rubrics (Value Added Learning in Undergraduate Education.)

These outcomes outline important expectations for higher education.

Click HERE to visit the AAC&U website that outlines each of these areas.

KVCC and the Educated Person (Essential Learning Outcomes)

Kennebec Valley Community College has adopted a number of recognized general education learning outcomes (aligned closely with the VALUE Rubrics) to provide an operational definition of the outcomes we ensure all students have upon graduation from any program.

Here is a summary of the KVCC Essential Learning Outcomes

Critical Thinking is a habit of mind characterized by the comprehensive exploration of issues, ideas, artifacts, and events before accepting or formulating an opinion or conclusion. (AAC&U)

Problem Solving is the process of defining the problem, designing, evaluating and implementing a strategy to answer a question, achieve a desired goal, or reach a solution. (AAC&U modified)

Quantitative Reasoning also known as Numeracy or Quantitative Literacy (QL) - is a habit of mind characterized as competency in working with numerical data. Individuals with QR skills possess the ability to reason and solve quantitative problems from a wide array of contexts. They understand and can create reasonable sophisticated arguments supported by quantitative evidence and they can clearly communicate those arguments in a variety of formats (using words, tables, graphs, mathematical equations, etc., as appropriate). (AAC&U modified)

Effective Communication is the transactional process of sending and receiving verbal, nonverbal, and visual symbols to create and share meanings based on form and purpose.

Students will demonstrate effective communication in written communication.

Written Communication is the development and expression of ideas and information in writing. Written communication involves learning to work in many genres and styles. Written communication abilities develop through iterative experiences across the curriculum. (AAC&U modified)

And students will demonstrate effective communication in one or more of the following ways:

- **Oral Communication** is a prepared and delivered purposeful presentation designed to increase knowledge, to foster understanding, or to promote change in the listeners' attitudes, emotions, values, beliefs, or behaviors. (AAC&U modified)

- **Interpersonal Communication** is the process of message transaction between two or more people for developing and maintaining professional and personal relationships. (West & Turner; University Nebraska Lincoln)
- **Teamwork** consists of the behaviors under the control of individual team members (effort they put into team tasks, their manner of interacting with others on team, and the quantity and quality of contributions they make to team process) to achieve mutual goals. (AAC&U modified)

What you will see...

To address this aspect of your education, we have designed a variety of assignments that engage students in higher-order thinking targeting a number of specific learning outcomes and contextualized within the course material.

You will find assignments throughout this program (in the CourseBooks) that align with teaching and learning of EVERY one of the VALUE Rubrics and the KVCC ELOs. We feel it is essential that we address each of these across the curriculum to ensure that all of our graduates not only leave KVCC with the skills specific to their field, but the general abilities and knowledge that they need to be successful at anything they want to do.

It is hoped that most of these assignments could be categorized as “high-impact” activities. “High impact” activities may be defined as those that require a higher degree of creativity, engagement, attention, and an ability to integrate information and skills.

In addition...

You might, on occasion, see other types of assignments in this section. Assignments that are important to the course but are not necessarily identified as “Signature Assignments” or aligned with a specific general education learning outcome.

These assignment will still be high impact and engaging.

Ethical Reasoning

Using Ethical Guidelines

Learning Outcomes

- Create realistic scenarios that provide ethical challenges to case managers.
- Apply the MHRT/C Code of Conduct to solutions for these challenges.

PART I - GROUP WORK - Working withe the MHRT/C Code

This assignment will entail working in small groups to explore decision making related to the MHRT/C Code of Conduct.

1. Each of you will be assigned into a small group.
2. Each group will be assigned ONE of the Standards listed in the MHRT/C Code of Conduct.
3. Working together the group will create a "case study" that exemplifies a problem situation in which this standard could be applied. ("Case Manager Bob made an appointment with his first client of the day, Helen...and so on)
4. The “case study” will consist of two parts:
    - A word for word copy of the specific standard you are applying.
    - The “story” about the situation that brought about the ethical conflict.

- The solution that your group came up with that both deals with the ethical dilemma, but also helps the client or worker to change and learn from the situation.

5. The group will post a final document in their group discussion board.

The group will be graded on this assignment based on the finished product.

PART II - INDIVIDUAL WORK - ACA Code of Ethics Quiz

Once all of the Group Work is done, your Professor will construct a quiz based on each of these Case Studies.

The quiz will include each Case Study from each group and identify the Standard in which the group was working.

For each case study you will all need to identify the specific Section in the ACA Code of Ethics (you will copy the entire Section word-for-word in your answer).

Each of you must complete this task for EACH case study, including the one your group completed.

These questions will be posted in the Ethical Reasoning Quiz

Grading this Assignment

After this is all done the grade for the whole assignment will be based on the following:

- Individual participation in the group the creation of the Case Study (30%)
- The actual Case Study document - 1 grade per group (20%)
- Individual performance on the ACA Code of Ethics Quiz (50%)

Inquiry and Analysis

Counseling Topics Presentation

Learning Outcomes

- Identify a creative, focused, and manageable topic.
- Synthesize information from a variety of sources.
- Outline conclusions on the topic with support from your sources.
- Identify limitations and implications for personal practice based on the conclusions.

Research and Presentation

This particular assignment is going to ask you to do some basic research to learn about a topic related to counseling psychology. Your task will be to explore a sample of the existing professional literature and create an online presentation which explores and teaches others about the topic.

Selecting a Topic

Click HERE for a Wikipedia based list of topics. Select from one of these. (If you click on the actual link for you topic you will be brought to the information page within Wikipedia. Sometimes you can find links to peer reviewed articles right in there!)

Working with Topics

The list that is mentioned above is a "starting point" in your topic selection. Essentially, research sets out to answer questions, so you need to formulate a question in your mind as you approach doing research.

Let's say you picked "email counseling" as your topic from the list I provided...you want to formulate a specific question about email counseling that you can research...here are some examples:

- "How effective is email counseling?"
- "What are the ethical guidelines related to email counseling?"
- "What email counseling services are available in Maine?"
- "To what extent do insurance companies reimburse for email counseling?"

THESE are the types of questions you begin to do your research on. For THIS assignment you should start on the web with simply Google searches. Eventually you need to have 4 sources of information that you use as the basis for your presentation.

ONE of those sources needs to be "Peer Reviewed" so be sure that you understand what a peer reviewed sources is. I've included some links below to help with that.

What is a Peer Reviewed article?
Using Google for research?
Using Online Databases for Research.

Information related to APA Format, using KVCC Library Services, and doing Literature Reviews can all be found in the MH Core Content CourseBook.

Text Link

Steps in the Process

1. Select a topic and get approval for the topic from your instructor.
2. Conduct research on the topic that includes information from FOUR sources with AT LEAST ONE "peer reviewed" journal article...additional information can come from other sources.
3. Prepare your presentation using Adobe Spark Video.

4. You will be sharing your presentation with members of the class in a special discussion board and the presentations will become a permanent part of this class!

Click the app icon below to get this app!

Text Link

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Presentation Tips

Keep in mind that this is a presentation...this means that the total of what you are submitting consists of graphic/word representations of the information you discovered in your research and your recorded voice.

This means that your slides do not need to contain EVERY word that you say! Your slides should be simple, attractive, colorful, and meaningful. The voice-over is where you will go into some additional details to explain the content of the slides.

Also, be sure to include your APA citations for ALL of your sources in your presentation.

Make sure you EXPLICITLY cover every aspect of the items in the grading rubric.

Grading rubric Counseling Topic Presentation

Lab Manual

14

About this Lab Manual

Demonstrating your Skills

Interviewing and Counseling skills, as outlined in this CourseBook, are some of the most essential and important skills you will need and utilize in your work.

While learning about these skills on a theoretical and conceptual level is important, being able to demonstrate these capacities is important.

The Lab Manual portion of this CourseBook focuses on a set of specific assignments where you will be asked to demonstrate a number of the skills you have been learning about. There are a total of 5 Labs outlined here:

- **Lab 1: Informed Consent and OARS**
    - This lab will have you demonstrate how to go about providing a complete and valid informed consent that covers client rights, risks and benefits of treatment, and confidentiality.
- **Lab 2: Focusing and Evoking**
    - Lab 2 deals with determining a focal point for the session, exploring emotional and motivational factors for change, and evoking ideas related to strengths, barriers, and tentative planning.
- **Lab 3: Motivational Interviewing and Treatment Planning**
    - This lab will have you engage in all aspects of the MI process leading to the development of a complete Treatment Plan that addresses barriers to the client's goals.
- **Lab 4: Motivational Interviewing, Follow-up, and Termination**
    - Working with the same client you did in Lab 3, this session will focus on following up on an existing Treatment Plan, determination of success, and the process of terminating services.
- **Lab 5: Single-Session MI Process**
    - The final lab represents an opportunity for you to demonstrate the entire process. Expectations in this session

will include Informed Consent, the MI process, Treatment Planning, and a determination of what factors (success or lack of progress) that would lead to termination of services.

Procedures and Technology

This CourseBook is designed for content delivery in an Online environment, so these instructions will focus on how you may go about completing each of these labs based on that premise. However, you may be taking this class face-to-face or in a hybrid format. In those cases, your instructor will work with you to determine how they choose to have you demonstrate your skills.

For instance, it may be reasonable that many of the Labs could be conducted and evaluated an a face-to-face class with little or no technology required. Please work with your instructor to determine how they are going to conduct this aspect of the class.

Planning

Just like any process, these Labs entail a great deal of planning and coordination on the part of the student. Failure to plan is a plan to fail, so be sure to review when these Labs are due in your class and begin to make arrangements as soon as possible.

There are a number of considerations you should make as you are planning this out.

Finding Clients

For each of these Labs (with the potential exception of the LAST one, where you may have your instructor as your “client”), you need to find a willing partner (or partners) to play the role of the “client”.

It is critical that you find someone who is dedicated to helping you with this project and will take their role in your education seriously. While you don’t have to use the SAME person for each of these Labs, it is advisable to do so, and for Labs 3 and 4 you actually do need to use the same person.

It is also advisable that you use an ADULT who is NOT actually in need of counseling. The intent of this activity is to work on

YOUR skills, not to resolve the real-world issues that your client might bring up. Their situation or problem should be “fabricated and acted out” on the part of the client.

One great source of clients is, of course, your peers in this class. Networking with each other with the goal of finding “Lab Partners” is likely the best way for you to find a client.

Keep in mind that with the use of your iPad, you can use video conferencing technology to interact with your client. You don’t have to get together in the same physical space when there are video conferencing/recording options.

Specific instructions to the client are included in each of the descriptions of the Labs.

Reviewing and Practicing the Technology

The basic expectations (of the Online version of this CourseBook) is that you will create videos of your sessions using the tools, apps, and resources of your iPad.

Using these tools you will record your session demonstrating the skills outlined in the instructions, submit your video to an online video service, and then send the LINK to your video to your instructor per their instructions (or the instructions in the Lab).

The iOS and App Tutorial CourseBook has a specific section on recording video and uploading videos to the web for distribution. Please refer to that resources to explore your options.

It is vital that you experiment with your chosen method of recording/distributing early in the course so you can master these skills. Create practice videos and submit these links to your instructor for review to ensure that you know how you are going to submit your videos.

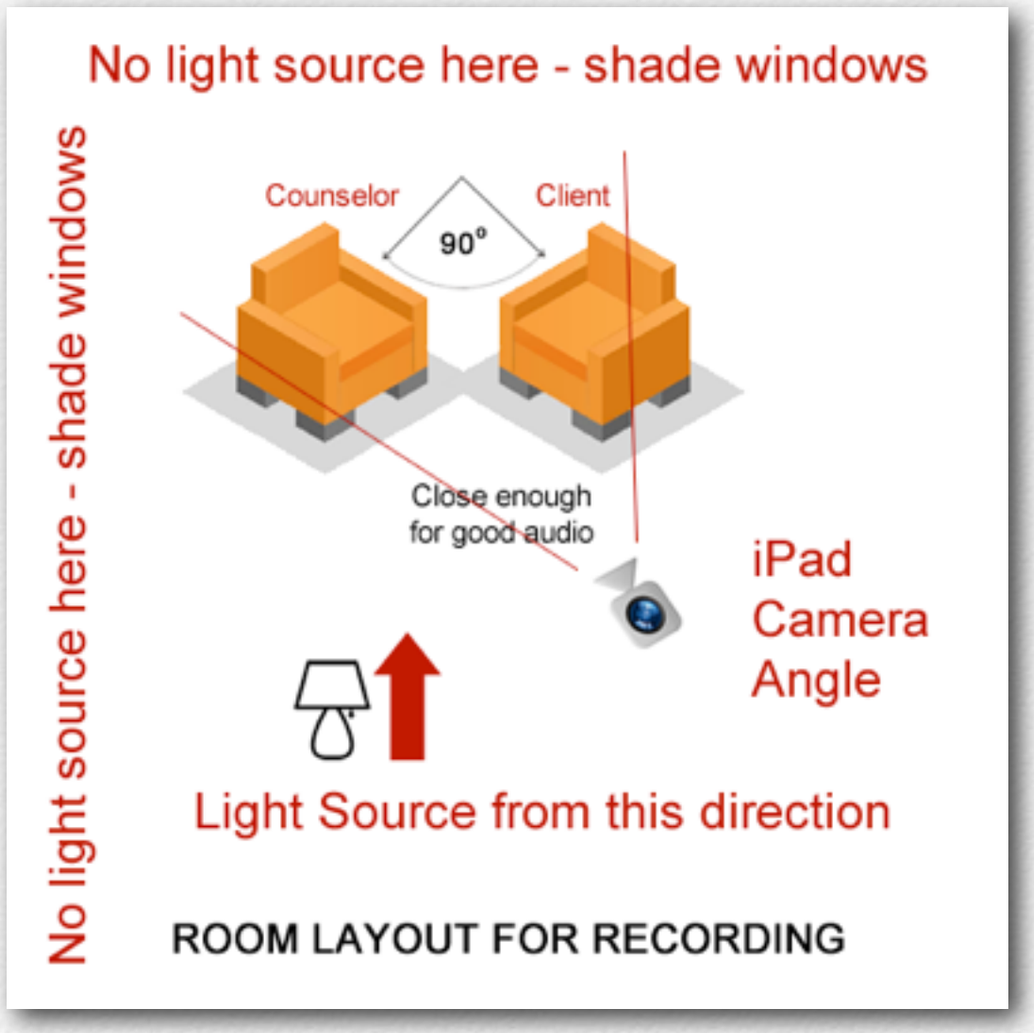
Setting the Stage

The assumption of these Labs is that you are demonstrating professional skills: the setting in which you conduct these sessions must be as professional as possible. (Keep in mind that you may be able to use these videos in the future to demonstrate your skills to potential employers!)

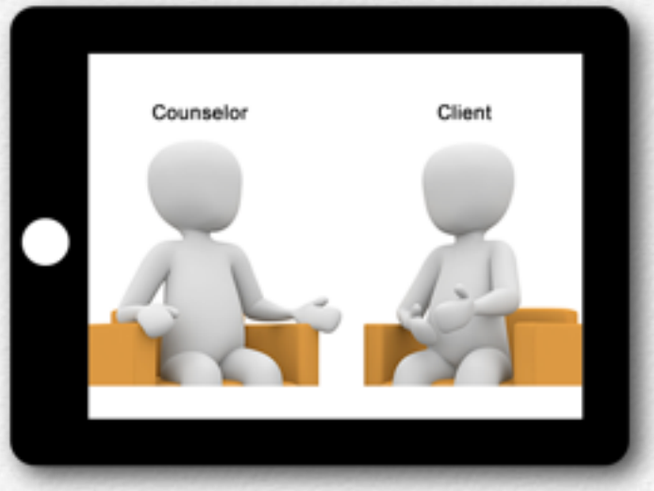
Here are some tips to keep in mind:

Tip #1: Space. Select a quite area undisturbed by non-participants (including family members, television, telephones, and pets.)

Tip #2: Room Layout. Seating arrangement, camera angle, lighting, and sound. Use the graphic below to optimize the quality of your video.



Tip #3: View from the iPad. You should record our video with your counselor and client in the frame...the point is the evaluate the COUNSELOR not the CLIENT! The example below is a straight on view, you could angle it so that they counselor is more the focus.



Tip #3: Editing. Once your video is completed you have the option to edit it using iMovie or any other app you find. HOWEVER, this is only to be used to cut off the beginning or ending of the session...I want to see the session as it happened, not as you edited it. So...you may need to record it a number of times to get it right.

Sharing your Work

Prior to sending your work out you want to review it for video and sound quality. Remember, this is just like doing a “spell- and grammar-check” prior to sending in a paper!

The iOS and App Tutorials CourseBook contains many tutorials on the different ways in which you can submit videos to the web, including YouTube and VIMEO.

Use the icon below to review resources on recording and sharing videos in the iOS and App Tutorials CourseBook.

Text Link

Complete the Assignments

Along with the video link, it is likely you will also need to submit other documents such as Treatment Plans. Submit these to the same drop box as you submitted the link to your video.

Rules about this whole Process

- Your sessions are to be treated with the same confidentiality that you would a "real" client. Real issues may come up and you need to give your “client” the same degree of assurance for confidentiality.
- It is YOUR responsibility to make the time and effort to ensure success in this part of the class.
- Technology problems do not excuse you from a responsibility to complete this assignment. Contact your Instructor if you need technology help.
- Check your audio and video quality as you are setting up to record and before you upload the file. It is always helpful to do a brief recording first to make sure everything is working as expected.
- Do not submit videos which include your set up time and your efforts to work out technology glitches in the software. Only hit record once you are ready to record.
- Be mindful of the setting and professional etiquette. You don't want family members, pets, unprofessional backgrounds, or food in your video.
- Stay positive...yes, this is a technical challenge...but it also part of the future of the work we do.

Lab 1

Informed Consent and OARS

Informed Consent

Read this document on Implementing Informed Consent.

Obtaining “Informed Consent” is a formal process of...

- Introduction and Credentials
- Defining “Case Management” and Services
- Risks and Benefits
- Confidentiality
- Clients Rights

Using OARS

Your performance will be evaluated based on your effective demonstration of the OARS skill set. We will be looking for instances of

- Open-ended Questions
- Affirmations
- Reflective Listening
- Summaries

CLIENT ROLE

The role of the Client can be to have issues or problems of any kind. The Client can make up a situation, use a real-life issue they are dealing with, or select from this LIST OF CASE STUDIES.

If your "client" tells a real story, please make sure to maintain confidentiality and inform the the person that the Instructor will be viewing the final product as part of your grade.

The Client could discuss:

- Financial issues
- Social skills

- Activities of Daily Living (ADL) skills
- Crisis (like you are being evicted - no crisis intervention sessions - that is a different class!)
- Goal accomplishment (new apartment, new job, new partner, etc.)
- Roommate issues
- Benefits issues (like you just lost your Medicaid/ MaineCare)

COUNSELOR ROLE

When you are the Counselor you are going to role play that you are the Client's "Case Manager" so you need to create a back story as well. Your agency, how long you have been there, etc. You can choose to use this same "agency" and back story for all of your sessions if you like.

Start each session with a brief introduction to yourself and your agency. Progress through a process of using OARS to explore the "client's" issue. End with a summary of the situation. We will not be doing treatment planning yet. You are simply gathering details of the person's story.

These videos should be no longer than 10 minutes long.

Feel free to use the editing tools in iMovie to add titles indicating when you performed each of these skills. This is optional but would make for a great reflective learning.

Submit the LINK to the RECORDED SESSION to the appropriate drop box.

Grading Rubric for Lab 1

Lab 2

Focusing and Evoking

This Lab will have you performing all but the last part of the MI process (Planning) in an effort to have you focus on the process of "Getting to the Plan."

Informed Consent

In this session you will, again, go through the process of Informed Consent. You can, however, make it more brief and just review the client's understanding of these concepts verbally.

Engaging - Use OARS skills to explore the client's story.

- Open-ended Questions
- Affirmations
- Reflective Listening
- Summaries

Focusing

- Establish a clear focal point to work on in the session.

Evoking - Use EARS to explore past efforts, successes and confidence in bringing about change.

- Explore
- Affirm
- Reflect
- Summarize
- Identify and resolve barriers to change.
    - This is where we confront the internal and external barriers to change. We need to counter the attitudes, expectations, and other real barriers to change. In fact, a lot of our planning may focus on removing specific barriers.
- Focus on past successes.
    - We are continually focused on our clients' strengths. Regardless of their past and circumstances, they have had successes in the past. Begin to explore how the skills

used in other circumstances will help them in their current circumstances.

CLIENT ROLE

The role of the Client can be to have issues or problems of any kind. The Client can make up a situation, use a real-life issue they are dealing with, or select from this LIST OF CASE STUDIES.

If your "client" tells a real story, please make sure to maintain confidentiality and inform the the person that the Instructor will be viewing the final product as part of your grade.

The Client could discuss:

- Financial issues
- Social skills
- Activities of Daily Living (ADL) skills
- Crisis (like you are being evicted - no crisis intervention sessions - that is a different class!)
- Goal accomplishment (new apartment, new job, new partner, etc.)
- Roommate issues
- Benefits issues (like you just lost your Medicaid/ MaineCare)

COUNSELOR ROLE

When you are the Counselor you are going to role play that you are the Client's "Case Manager" so you need to create a back story as well. Your agency, how long you have been there, etc. You can choose to use this same "agency" and back story for all of your sessions if you like.

Your session should be outlined in the following manner:

- Introduction of yourself to the client including your name, your agency, and your qualifications.
- A review of information to assure "Informed Consent" (See this information from Lab 1.)
- Engage the client in the MI processes of Engaging, Focusing, and Evoking.
- End the session like you are “out of time” and need to go to your next appointment. Remember to play out this session as it would occur with a real client so every detail needs to be followed up on.
- Submit the LINK to the RECORDED SESSION to the appropriate drop box.

These videos should be no longer than 10 minutes long.

Feel free to use the editing tools in iMovie to add titles indicating when you performed each of these skills. This is optional but would make for a great reflective learning.

Submit the LINK to the RECORDED SESSION to the appropriate drop box.

Grading Rubric for Lab 2

Lab 3

Motivational Interviewing and Treatment Planning

In this Lab you are going to demonstrate the entire process of meeting a client for the first time, going through the process of MI to the point of creating a Treatment Plan.

Lab 3 and Lab 4 need to be conducted using the same client. You will be building a plan in this Lab and following up and terminating services after a success plan in the next Lab.

Informed Consent

In this session you will, again, go through the process of Informed Consent. In this Lab you need to go through the entire process of reviewing the components of Informed Consent and getting signatures as you did in Lab 1.

Obtaining “Informed Consent” is a formal process of...

- Introduction and Credentials
- Defining “Case Management” and Services
- Risks and Benefits
- Confidentiality
- Clients Rights

LINK TO HANDOUT ON INFORMED CONSENT

Engaging - Use OARS skills to explore the client's story.

- Open-ended Questions
- Affirmations
- Reflective Listening
- Summaries

Focusing

- Establish a clear focal point to work on in the session.

Evoking - Use EARS to explore past efforts, successes and confidence in bringing about change.

- Explore
- Affirm

- Reflect
- Summarize
- Identify and resolve barriers to change.
    - This is where we confront the internal and external barriers to change. We need to counter the attitudes, expectations, and other real barriers to change. In fact, a lot of our planning may focus on removing specific barriers.
- Focus on past successes.
    - We are continually focused on our clients' strengths. Regardless of their past and circumstances, they have had successes in the past. Begin to explore how the skills used in other circumstances will help them in their current circumstances.

Treatment Planning - Develop a Treatment Plan for your Client

- Be sure that the development of your plan is clearly outlined during your recorded interview session. Your ending summary statements before the end of the session should summarize every detail of the plan.
- Your plan will be written using the Treatment Plan Format covered in the MH Core Content CourseBook.
- Understand impact of significant others.
    - Bring others in for support! Change works a lot better when others are there to help and support the person through the process.
- Preparation - specific steps, dates, supports, resources, etc.
    - As you are going through this process you are beginning to formulate the specifics of the planning process you will engage in next.

CLIENT ROLE

The role of the Client can be to have issues or problems of any kind. The Client can make up a situation, use a real-life issue they are dealing with, or select from this LIST OF CASE STUDIES.

If your "client" tells a real story, please make sure to maintain confidentiality and inform the the person that the Instructor will be viewing the final product as part of your grade.

The Client could discuss:

- Financial issues
- Social skills
- Activities of Daily Living (ADL) skills

- Crisis (like you are being evicted - no crisis intervention sessions - that is a different class!)
- Goal accomplishment (new apartment, new job, new partner, etc.)
- Roommate issues
- Benefits issues (like you just lost your Medicaid/ MaineCare)

COUNSELOR ROLE

When you are the Counselor you are going to role play that you are the Client's "Case Manager" so you need to create a back story as well. Your agency, how long you have been there, etc. You can choose to use this same "agency" and back story for all of your sessions if you like.

Your session should be outlined in the following manner:

- Introduction of yourself to the client including your name, your agency, and your qualifications.
- A comprehensive review of information to assure "Informed Consent" (See this information from Lab 1.)
- Engage the client in the MI processes of Engaging, Focusing, Evoking, and Planning
- End the session like you need to write up the formal plan and set the appointment for follow up. Remember to play out this session as it would occur with a real client so every detail needs to be followed up on.
- Submit the LINK to the RECORDED SESSION to the appropriate drop box.

Feel free to use the editing tools in iMovie to add titles indicating when you performed each of these skills. This is optional but would make for a great reflective learning.

Submit the Treatment Plan

Using the format outlined in the Core Content CourseBook, write your Treatment Plan and submit it to the appropriate drop box.

Text Link

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Grading Rubric for Lab 3

Lab 4

Motivational Interviewing - Follow-up and Termination

In this Lab you are going to demonstrate the process of a “Follow Up” session with the SAME CLIENT FROM LAB 3.

entire process of meeting a client for the first time, going through the process of MI to the point of creating a Treatment Plan.

Informed Consent

In this session you will, again, go through the process of Informed Consent. You can, however, make it more brief and just review the client’s understanding of these concepts verbally.

Engaging - Use OARS skills to check in on the client and explore if there are any new issues or problems that have come up.

- Open-ended Questions
- Affirmations
- Reflective Listening
- Summaries

Focusing

- Establish the focal point of the session as a review of progress on the Lab 3 Treatment Plan.

Evoking - Use EARS to find out how the plan went.

- Explore
- Affirm
- Reflect
- Summarize - be sure to summarize the success of your client and the success of the plan.

Termination Planning - Develop a Termination Plan for your Client

- Termination planning is every bit as important as Treatment Planning.

- Following your discussion about the Termination of Services, you will draft a “Termination Letter”. This letter is a formal letter and is written using a business letter format. Create your own letterhead and make the letter look as professional as possible.
- **Contents of the Termination Letter** - The contents of this letter should include the following (be sure to include EACH and every part in your letter)
    - Draft a statement that informs the client what termination of treatment is and that emphasizes that it is the client’s responsibility to personally seek further treatment if appropriate.
    - Include your client’s name (no “Dear Client” form letters).
    - Identify the date when therapy began.
    - Note the termination date.
    - Relate the primary and secondary diagnosis or, if no diagnosis was give, relate the primary cause for treatment.
    - Describe the reason for termination.
    - Summarize treatment, including any need for additional services.
    - If you feel further treatment is advisable or necessary, make that explicit in your letter.
    - List three or more referrals or referral sources, including addresses and phone numbers.

CLIENT ROLE

The role of the client at this point is to act the part of a client who has successfully completed the plan that you worked on in Lab 3. Create a rich story regarding your success and what you had to do to overcome barriers.

The point is to move toward terminating services with the counselor.

COUNSELOR ROLE

When you are the Counselor you are going to role play that you are the Client's "Case Manager" so you need to create a back story as well. Your agency, how long you have been there, etc. You can choose to use this same "agency" and back story for all of your sessions if you like.

Your session should be outlined in the following manner:

- This is the second session with this same client, so the beginning of the session can be much more informal.

- A review of information to assure "Informed Consent" (See this information from Lab 1.)
- Engage the client in the MI processes of Engaging, Focusing, Evoking, and Termination Planning as outlined in this Chapter.
- End the session summarizing your work together, successes, and a positive sense of accomplishment. It is OK to talk about how you may address each other if you see each other in public places.
- Submit the LINK to the RECORDED SESSION to the appropriate drop box.

Feel free to use the editing tools in iMovie to add titles indicating when you performed each of these skills. This is optional but would make for a great reflective learning.

Submit the Termination Letter

Using the format outlined, write your Termination Letter and submit it to the appropriate drop box.

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Grading Rubric for Lab 4

Lab 5

Final Session

In this "final" for the class you will communicate with your instructor and arrange to meet in order to conduct a counseling session and treatment planning meeting. In this process you are going to utilize the above mentioned skills to conduct an initial interview and treatment plan for a client.

This meeting may take place face-to-face or you may need to negotiate using one of the video recording options. You will work this out with your instructor.

Your instructor will role play a case study. Utilizing the skills you have learned in this class you will engage the "client" in a counseling session.

At the conclusion of your interview session you will construct an initial treatment plan which identifies what you are "going to do" with this client. It must cover all of the areas outlined above and must be "real" and "pragmatic".

Any skill training needs to include a brief "Lesson Plan" that indicates the specific steps for skill training and an assessment as to how you will KNOW that the skill has been attained.

Any referrals need to be identified as real agencies and/or services located in the person's area.

You will format this document in a professional manner and submit it to your instructor through the assignment drop box provided for this purpose within 24 hours of your scheduled appointment.

The structure of this Lab is identical to Lab 3.

Informed Consent

In this session you will, again, go through the process of Informed Consent. In this Lab you need to go through the entire process of reviewing the components of Informed Consent and getting signatures as you did in Lab 1.

Obtaining “Informed Consent” is a formal process of...

- Introduction and Credentials
- Defining “Case Management” and Services

- Risks and Benefits
- Confidentiality
- Clients Rights

LINK TO HANDOUT ON INFORMED CONSENT

Engaging - Use OARS skills to explore the client's story.

- Open-ended Questions
- Affirmations
- Reflective Listening
- Summaries

Focusing

- Establish a clear focal point to work on in the session.

Evoking - Use EARS to explore past efforts, successes and confidence in bringing about change.

- Explore
- Affirm
- Reflect
- Summarize

- Identify and resolve barriers to change.
  - This is where we confront the internal and external barriers to change. We need to counter the attitudes, expectations, and other real barriers to change. In fact, a lot of our planning may focus on removing specific barriers.
- Focus on past successes.
  - We are continually focused on our clients' strengths. Regardless of their past and circumstances, they have had successes in the past. Begin to explore how the skills used in other circumstances will help them in their current circumstances.

Treatment Planning - Develop a Treatment Plan for your Client

- Be sure that the development of your plan is clearly outlined during your recorded interview session. Your ending summary statements before the end of the session should summarize every detail of the plan.
- Your plan will be written using the Treatment Plan Format. LINK TO TREATMENT PLANNING PAGES IN CORE CONTENT.
- Understand impact of significant others.

- Bring others in for support! Change works a lot better when others are there to help and support the person through the process.

- Preparation - specific steps, dates, supports, resources, etc.

- As you are going through this process you are beginning to formulate the specifics of the planning process you will engage in next.

CLIENT ROLE

Since your instructor will likely be playing this role, they are responsible for coming up with a rich case study to role play.

The goal is not to trip you up, or place you in an uncomfortable place. This Lab is your opportunity to show you instructor your current level of skill. Learning how to do this, particularly under the pressure of these labs, takes years of practice.

Be confident that this is an assessment to determine your current level of skill of Consent, the MI process, and Treatment Planning.

COUNSELOR ROLE

When you are the Counselor you are going to role play that you are the Client's "Case Manager" so you need to create a back story as well. Your agency, how long you have been there, etc.

You can choose to use this same "agency" and back story for all of your sessions if you like.

Your session should be outlined in the following manner:

- Introduction of yourself to the client including your name, your agency, and your qualifications.

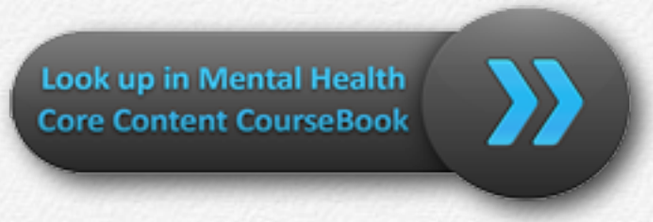
- A comprehensive review of information to assure "Informed Consent" (See this information from Lab 1.)

- Engage the client in the MI processes of Engaging, Focusing, Evoking, and Planning

- End the session like you need to write up the formal plan and set the appointment for follow up. Remember to play out this session as it would occur with a real client so every detail needs to be followed up on.

Submit the Treatment Plan

Using the format outlined in the Core Content CourseBook, write your Treatment Plan and submit it to the appropriate drop box.



Text Link

Write your Treatment Plan and submit it to the appropriate drop box **within 24 hours of the session.**

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Grading Rubric for Final Session