

# Core values and guiding principles of counseling



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## Core Values and Guiding Principles of Counseling

In the world of counseling, there are 6 guiding core values that impact clinical work on a daily basis. Those principles are autonomy, nonmaleficence, beneficence, justice, fidelity, and competency. Autonomy is the first guiding principle. This value addresses the idea of independence. This means allowing the client the space to make their own choices and be responsible for their actions. This also means being able to recognize when it is appropriate or not to encourage the client to make certain decisions based on factors such as intellectual functioning, mental illness, or age (Forester-Miller, Ph. D. & Davis, Ph. D., 1996.) The second guiding principle is nonmaleficence. This is the concept of not causing harm to others. This concept refers to not intentionally inflicting harm upon others, as well as, refraining from engaging in any behaviors that may inflict harm onto others (Forester-Miller & Davis, 1996.)

The third guiding principle follows closely with the principle nonmaleficence. The third guiding principle is beneficence. Like the idea of “do no harm,” beneficence refers to the counselor’s responsibility to contribute to the welfare of the client, including but not limited to, taking preventative actions to protect the client from harm, whenever possible (Forester-Miller & Davis, 1996.) The fourth principle is justice. This principle refers to the counselor’s responsibility to treat all individuals in a fair manner and if the counselor were to approach a client different from their normative approach, they are responsible for explaining this rationale to the client (Forester-Miller & Davis, 1996.)

The fifth and sixth guiding principles are fidelity and competence. When adhering to fidelity, the counselor is showing loyalty and establishing trust with the client by honoring commitments and maintaining confidentiality. However, it is important that the client also is aware that fidelity can be broken when counselors are trying to adhere to the guiding principle of beneficence (Forester-Miller & Davis, 1996.) Likewise, the guiding principle of competence is the counselor's obligation to stay up to date on all licenses/certifications, ethical standards, multicultural competencies, and to practice these guiding principles on a daily basis.

By taking into consideration these 6 factors and practicing these principles in their practice daily, counselors stand the best chance of being prepared, confident, and ethical in therapeutic settings. Additionally, without maintaining these principles in therapeutic settings, there is a slim chance that a solid therapeutic alliance can develop. Without a therapeutic alliance it becomes an uphill battle to gain the client's trust and create an atmosphere where the client feels the room to grow, become more self-reliant, and cope with everyday challenges with more ease.

Diagnosis and Justification:

1. Diagnosis:

- o F10. 10 Alcohol Use Disorder- Moderate
- o F32. 9 Unspecified Depressive Disorder
- o Z56. 9 Other Problem Related to Employment
- o R/O F40. 10 Social Anxiety Disorder

## 2. Justification for diagnosis:

Due to Fred's own self-report, Fred is currently experiencing about 3-4 of the criteria needed for Alcohol Use Disorder, which qualifies his diagnosis as moderate (American Psychiatric Association, (APA,) 2013,) despite, Fred's report of not being an alcoholic. By his own reports, Fred has experienced recurrent use resulting in failure to fulfill major role obligations (APA, 2013,) as evident by dismissal from his place of employment. Fred seems to continue use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of alcohol (APA, 2013,) as evident by his recent romantic break up. Fred reports recurrent alcohol use in situations that are physically hazardous (APA, 2013). Fred continues to struggle with his diabetes and has been advised by a doctor to stop drinking.

Fred shows characteristic symptoms of a depressive disorder that cause clinically significant distress or impairment in his daily activities of life. Fred expresses feelings of being alone, feelings of isolation, feeling as if something is wrong with him, and has experienced weight gain. However, currently Fred does not meet the full criteria for a depressive disorder (APA, 2013.) This diagnosis serves to show Fred struggles with depressive symptoms, but factors such as Fred's current alcohol use, make it challenging to discern if depressive symptoms are due to his Alcohol Use Disorder or an undiagnosed Major Depressive Disorder diagnosis, as alcohol is a system depressant (APA, 2013.) Continued observation and mood monitoring may disprove or solidify a full depressive disorder diagnosis.

Fred also self-reports having feelings of fear and anxiety in social situations. Currently, Fred reports feeling rushes of terror, heart palpitations, and

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gastrointestinal issues, in response to social situations or the thought of social situations which are criteria for Social Anxiety Disorder (APA, 2013). While it is evident that Fred's fear and anxiety has impacted his social and occupational life, such as avoiding social events or job interviews, it is unclear in his initial self-report if these symptoms have been impacting him for more than 6 months (APA, 2013.) Fred mentioned feelings of "awkwardness" for as long as he can remember, however, until recently this trait seemed to have little effect on Fred's functioning in daily life. If symptoms Fred's systems continue to be intrusive enough to interfere with Fred's daily functioning for 6 months or more, the diagnosis can be solidified as Social Anxiety Disorder or ruled-out as symptoms of a differential diagnosis.

Lastly, due to Fred reporting recent dismissal from his work place and challenges in finding new work, Fred received a z-code for employment related issues. This code is only issued when the occupational challenges call for significant clinical attention impacting treatment goals (APA, 2013.) Due to Fred's self-disclosure around having significant difficulties in finding and maintaining work as of lately, this solidified employment related issues as clinically significant to this case.

### Theoretical Approach

The theoretical approach used while working with Fred would be Cognitive Behavioral Therapy (CBT). CBT functions from the perspective that individuals' experience three levels of cognitions. Those various levels of cognitions then have effects on behaviors and/or behaviors have effects on

those cognitions. The three levels of cognitions are: automatic thoughts, intermediate beliefs, and core beliefs. When working with clients from a CBT approach it is important to first establish a therapeutic alliance with the client where they feel safe, supported, and empowered by the work done in therapy. Additionally, it is important to refrain from viewing the client's beliefs or behaviors as good or bad, but rather more or less adaptive (Beck, 23.)

During a lecture in August of 2019, presenter Robert Hindman, PhD of the Beck Institute for Cognitive Therapy, explained automatic thoughts are quick, evaluative thoughts or images tied closely to a specific emotion, which usually goes unnoticed by the client. Automatic thoughts are generally interpretations the clients collect from the environment around them and when clients recognize an automatic thought, they often recognize it as true without challenging the observation. When trying to get the client to identify automatic thoughts, often times the clinician will pose questions such as: "What were you thinking in that moment?" "What emotions were you experiencing at the time?" or "What was going on for you physiologically at the time?" Once the clinician can help the client to identify automatic thoughts, further work can be done to help uncover the client's intermediate beliefs.

Hindman went on to explain that intermediate beliefs are thoughts that often take the form of conditional assumptions or rules. They develop through the client's interactions with others, society, and own personal values. They often take the form of "should." Examples of this are: "I should have done better," "they should respect me," or "I can't make mistakes."

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Intermediate beliefs show insight to the deeper cognitions the client is experiencing. Based on their past interactions and experiences, behaviors can then solidify or challenge a client's intermediate beliefs. Those intermediate beliefs can then work to challenge or strengthen the client's core beliefs.

Judith Beck, in her book *Cognitive Therapy for Challenging Problems*, explains that there are three subsets of core beliefs: hopelessness core beliefs, unlovable core beliefs, and worthlessness core beliefs (22.) Beck goes on to explain the importance of identifying which subset of core beliefs the client functions from. Proper identification is needed in order to begin to construct a proper framework of treatment for that client. By misidentifying which core beliefs, the client functions from can impact treatment negatively if not identified early (22.) Core beliefs are the central most beliefs about the client. These beliefs begin to form in early childhood and are considered fixed, absolute, truths (Hindman, Beck, & Broder, 2019.) Examples of core beliefs would be: " I am inadequate, ineffective, or incompetent," " I am powerless, trapped, and vulnerable," and " I am inferior, I am a failure, I don't measure up."

Conceptualization:

Growing up Fred was an only child. His mother passed away when he was six years old and was then raised by a strict father figure. He had a revolving maternal figure while his father was dating and Fred reports remembering his father's girlfriends trying to " stepmother" him with little success. Fred reported feeling a close bond to his grandmother growing up,

but at this time, both grandparents have passed away and Fred seems to lack social supports in his life. Due to the lack of consistent and loving supportive figures experienced by Fred during his fundamental developmental stages, it seems Fred has developed unlovable core beliefs.

Fred seems to be internalizing external factors in order to support his core beliefs of “ I’m not good enough,” “ I’m likely to be hurt,” and “ I can’t cope.” Examples of external factors supporting his core beliefs could be dismissal from his job, his recent romantic break-up, lack of friends, and his mother’s death in early childhood. Fred’s early childhood experience of real or perceived abandonment has continued to impact Fred into adulthood, engraining themselves in his core beliefs. Additionally, it seems as though Fred’s anxiety in social situations have recently become so overwhelming, Fred has begun to use avoidance as a compensatory strategy to defend himself against rejection. Fred also reports self-isolating and using alcohol as a preferred coping strategy. If Fred continues to engage in compensatory strategies, rather beginning to challenge his core beliefs, Fred will stay stagnate in therapy. Once Fred can begin to recognize his beliefs, he can work on modifying behaviors, challenge maladaptive beliefs, and learn more adaptive coping skills, increasing the likelihood of his success in treatment.

Goals of Treatment:

1. Find one activity that brings satisfaction to Fred
2. Start a list of preferred areas of interest for employment
3. Engage in preferred activity to clear away unwanted thoughts

Working with the Client:

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Since Fred is coming to treatment primarily for his feelings of isolation and fear in social situations impacting his daily life but also has many of other factors of clinical significance going on, the first type of question, I would ask Fred would be an imagery question. Using imaginal techniques can help clients who are having difficulty setting goals in treatment. Imagery questions can help the client speak in broad terms about what they want from therapy while the clinician works in tandem with the client to come up with more suitable and attainable goals. In the early phase of treatment, I would utilize this type of question with Fred. Fred is given the room to explore what he wants out of therapy without my perspective of Fred's challenges potentially skewing his perspective of what he wants to work on in therapy. I would ask Fred questions such as "How would you like your life to be different as a result of therapy?" "What changes would you like to make in (work, relationships, etc.)?" or "What would your life look like if you woke up tomorrow and were happier?" An example of this might look like if I asked Fred, "How would you like your life to be different as a result of therapy?" and if Fred responded with something like:

"I don't know. I just feel so hopeless. Every time I go out and try to hang out with people, I just feel so overwhelmed, like everyone is annoyed I am there. So, I leave. Then I get home and start thinking about how I am never going to be able to be like normal people. It makes me really upset because every time I try to do something to bring me some joy, I freak out and have to leave. So, I just come home and drink and fall asleep trying to forget about how much people can't stand to be around me. I know I am supposed to be cutting down on the drinking because my doctor said so but it just

seems like every night I need something to help drown out all the negativity in my head.”

Although Fred states he is unclear on what he wants from therapy, there are a lot of big goals he touched on in his response. I can follow up and clarify what Fred said by responding with something like:

“ I know that you said you’re not sure what you want to work on, but I think you just gave me a lot of information. Correct me if I am wrong, but what I hear you saying is that you are having anxieties around interacting with others, lacking satisfying activities in your life, and drinking more than you want despite doctor’s orders to calm your head at night. I think that, if you’re willing, we can try to work with together to come up with some smaller goals to help us start tackling those bigger problems. What do you think?”

If Fred felt comfortable with this, I would start therapy by introducing Fred to thought records and cost-benefit analysis charts to help him in between sessions to monitor and become more aware of maladaptive automatic thoughts. By teaching Fred to use thought records and cost-benefit analysis charts, he will be enabled with the ability to recognize distressing situations, thoughts commonly associated with the situation, and alternative thoughts to help balance and center Fred during times of distress. Additionally, reviewing these records/charts in session will help me to better understand the intermediate and core beliefs Fred functions from. Another intervention likely to be used with Fred would be behavioral experiments. Due to his symptoms of anxiety around social situations, systematic desensitization will

help Fred to re-integrate and feel safe in social situations. I would also encourage Fred to carry around a coping card or a Socratic questioning card.

Currently, I feel Fred is in the contemplation stage of change for some aspects of the clinical work needed to facilitate positive change in Fred's life. He acknowledges that he has a lot going on and there are some things he is willing to work on. However, there are other areas where Fred seems to be still stuck in the precontemplation phase of change. For example, Fred reports not viewing alcohol use as a major issue, despite the threat to his health with continued use. Therefore, I would be apprehensive to tackle bigger issues such as, finding a job or alcohol use, since those factors may be too large for Fred to handle at the time, nor does Fred seem to recognize these as reasonable or obtainable goals at present. If I push these goals, rather than coming up with smaller, more obtainable goals collaboratively with Fred, I may risk causing Fred to become resistant to treatment. But working together and making manageable goals that are important to Fred will increase the likelihood of meeting those goals and progressing in treatment. Termination date will be dependent on Fred's receptiveness to treatment.

#### Assessment Tools:

An assessment tool that would be utilized in Fred's case would be the Beck Depression Inventory-II or the BDI-II. The BDI-II is used to assist the clinician and the client to identify the level and severity of depressive symptoms (Beck Depression Inventory®-II (BDI®-II)),(n. d.) It is a relatively short self-report questionnaire. The BDI-II tends to take 5 minutes to complete and

consists of 21 items which all have four responses, ranging in severity or frequency (BDI®-II, (n. d.) This assessment is appropriate for ages 13 and above and can be scored by the clinician directly after administration (BDI®-II, (n. d.) By utilizing this assessment weekly with Fred, his depressive symptoms can be monitored and measured aiding the clinician in ruling out his unspecified depressive disorder. Additionally, it may help Fred identify atypical symptoms of depression which he normally would not recognize as such.

#### Multicultural Factors Impacting Treatment:

Fred is a middle aged, African-American man. Fred discloses a recent romantic break-up but does not include gender modifiers while speaking about the relationship and his sexual orientation cannot be assumed. Additionally, Fred did not disclose any religious information upon intake interview. More information is also needed surrounding his current socioeconomic status. Fred reports growing up in a wealthy household, but recently lost his job and may need financial assistance while looking for work to support him. Growing up, Fred reports his mother's death around a critical developmental period in Fred's life. Due to this, he grew up in a household with a stern yet ambivalent parental figure and much alone time due to Fred being an only child. Finally, Fred self-disclosed a history of alcoholism in close family members. Fred's grandfather died due to cirrhosis, further increasing his potential risk for Alcohol Use Disorder.

#### Ethical Challenges

When considering possible ethical issues with this case, the concept of countertransference comes to mind. This is due to my own history with alcoholism. I worry there is a chance that I could self-project onto Fred. Furthermore, since I am so embedded in my own program, there is a chance that Fred could remind me of someone else I know, which could skew my perspective of Fred. Additionally, I struggle with Panic Disorder, which potentially could cause countertransference between Fred and myself due to his symptoms of panic in social situations. I believe that these factors could be an asset for me to empathize with Fred, if kept in check. However, without having consultation about the case, I would be worried I would cross ethical boundaries due to countertransference, if not identified early while working with Fred.

Furthermore, my apprehensions about Fred's case extend beyond countertransference. When working with individuals with substance-abuse disorders, I worry about the ethical concepts of dual relationships and conflicts of interest. The brief work I have done with individuals with substance-abuse disorders running out-patient groups, I quickly found myself seeing clients outside of the therapeutic setting which, in turn, impacted both my recovery, as well as, the client's recovery at the time. I feel at this time the drug and alcohol population is not who I am best suited for. However, with time, supervision, increased competencies, and more self-reflection- perhaps one day I can be an asset to this field.

Consultation:

I would seek consultation early and often. If a case were to come to me where alcoholism or other substance abuse disorders were a key component of the client's diagnosis, I would want to work closely with another clinician to ensure I was maintaining ethical boundaries with the client. In Fred's case, I would be able to explore the reasons for and against self-disclosure related to Fred's case. I would be able to utilize and analyze my own thought records, role-play potential difficulties in session, and work to increase my own competencies. By doing this with another clinician, it can help to alleviate feelings of fear and anxiety, related to potential negative reactions to the client, self-disclosure, and ethical boundaries. An example of this might be, if Fred were to hit barriers in treatment, I may think to myself, "I know what it feels like, why can't he just deal with it." I feel my feelings of frustration would be disproportionate than if I were to be working with a client other than Fred whom I do not identify so closely with.

My experiences and Fred's, although similar, will never be the exact same and everyone's experience is different. I think consultation would help to keep me exploring deeper what is causing a disproportionate reaction in me to Fred's case, which in turn, will allow my skills as a clinician to deepen. Likewise, seeking consultation will help keep me in a grounded state of mind to be present with Fred in session and to remember to celebrate even the smallest of victories Fred accomplishes inside and outside of treatment.

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