

Counselling assignment



Counseling assignment March 16, 2007. Counseling Assignment Biography of Client The client is a 44-year-old Caucasian female, from a rural Southern Ontario background. The client is well educated and has worked as a teacher in the Elementary school system. At present, she is employed as a tutor for the adult learning center. The client identifies with no identifiable cultural or ethnic background, and firmly states, " I am a Canadian. " The client denies any religious affiliation or particular spiritual belief at the initial interview.

The client resides with her adult son, aged 20. The client also has two adult daughters that each live over two hours away. The setting in which the sessions were held, dates and length of client sessions The sessions were held at Dr. Hay's Owen Sound Office, Feb 15, 2007 and Feb 21, 2007. The intake interview was 1 hour, 15 minutes, and the subsequent interview was 45 minutes in duration. The presenting issue and/or problem from the client's perspective The client is upset because of her son's behaviour. Her son took an overdose of her pills, and lay down in the bed to die.

There was no suicide note, and he picked a time when no one would be home for quite a while. The son researched what would be a lethal dose of the mother's medication, and then ingested twice the lethal amount.

However the mother come home unexpectedly and found the son in his room unconscious. The son was transported to the hospital and expected to die. Fortunately, the son had also ingested Lasix with the sleeping pills (unnamed) and therefore a lethal dose was washed from his system (CPS, 2006). The patient's son recovered with no known physical effects from the overdose.

The second and most trouble difficulty for the client is the son's behaviour since recovering from the overdose. The son has refused to discuss the attempt with any caregivers from the unit within which he now resides. He participates in group therapy, but only insofar as to talk to people about their own behaviours. When asked about his feelings or behaviours, he refuses to discuss his thoughts, beliefs or emotions. This is very troubling to the mother, as she believes that he is waiting to exit the lockdown unit to attempt suicide again. She also described a confrontational meeting with the mental health team.

She believes that the team told her that she was the cause of his problems and her parentage of the child lead to the son's attempt and his subsequent behaviour. The client alternatively rejects this idea and then agrees with the notion that she is the root cause of the son's behaviour. The client believes if the son returns home without the root cause of the suicide attempt revealed or treated, then it will ' be a death sentence' for the son. The presenting problem from my perspective The presenting problem is not the son's behaviour, but the mother's reaction to the adult son's behaviour.

The mother believes that she alone is to blame for the son attempting suicide, and his subsequent behaviour towards the caregivers at the London Hospital. The client is also blaming herself for her daughters' reaction to the son's behaviour. This self-blame is reinforced by the daughters who tell her that she caused the son's suicide attempt by not being 'emotionally available' and by ' not recognizing the signs because she was too busy with work'. In short the presenting problem is related to the behaviours of the

offspring and the interactions between generations in the aftermath of the suicide attempt.

The mutually agreed-upon counseling goals and strategies •The client will like to get some community care for her son after his return home. A great deal of her stress is related to the idea that the son will not be followed or has any resources available to him once he leaves the hospital. •The client would like to live without the constant guilt that she currently feels for the son's situation. The client's " Stage of Change Behaviour" and the objective and subjective information that led you to identify this stage. The patient is in the stage of precontemplation.

She is observed to be in this stage because she is resistant to change her behaviour. Additionally, she doesn't have the insight to determine that " people are responsible for their own behaviour and how they react to other people's behaviour in their environment" (C. Marino, personal communication, 2001). The client stated that she would be fine if her son " stopped causing her grief". However, when queried about her reaction to the son's behaviour and actions, she just simply stated that the son could rectify the situation if he " would cooperate with the London people. The client was visibly upset during the interview and wringing her hands. When she would get to the most sensitive areas of her distress, she would make a joke and laugh at herself. However, the client stressed that she was not responsible for her distress, as it was her son's responsibility that she was upset.

Examples of the following skills if they were performed Ability to help the client tell their story. " Therapeutic building blocks" (Young, 2001, p. 30) is a

phrase used to describe the helping relationship and the components of that counseling relationship.

The ability to facilitate the client into relaying their story is the basis of therapy for change. I have listed my therapeutic helping skills below, and have described an example of each. Attending skills. The invitational skills are “ the basic means by which the helper invites the client into a therapeutic relationship” (Young, 2001, p. 30). I have utilized the nonverbal skills of eye contact, body position, attentive silence, voice tone, gestures and facial expressions, physical distance and touching where appropriate to facilitate the interviews into a therapeutic relationship.

One example of my attending skills is when I allowed a silence to follow a client’s final statement during the initial interview. The client thought about the situation during the silence, and then rephrased her difficulties into new thought i. e. “ Do you think that I am obsessing to much about whether he talks to his nurses? ” This use of silence allowed the client time to review what she had posited aloud. She then took the further step of reframing the thought into her own behavioural context as it related to her. Further discussion and examples of the helping skills are included in the specific headings below.

Use of empathy with the client “ Empathy not sympathy is the start of the therapeutic relationship. The client has to trust that you have some idea of how difficult their situation is for them” (J. Cotterell, personal communication, 1986). The trust that ensues from empathic listening provides the “ core conditions or supports for the other activities of the helper” (Young, 2001, p.

35). An example of empathy in a therapeutic relationship is when I said the to client, " It must be very difficult for you to cope with your son's behaviour" (First interview with client, Feb 21, 2007).

I was acknowledging the fact that her view of the situation is indeed very difficult for her to cope with, and that I understood what she was saying about the situation without specifically rephrasing. The client responded by leaning forward and proceeding to tell me about the nuances of her difficulties with her son. Use of probing statements, open-ended questions, closed questions All assessment techniques were used to ensure a full picture was given. When the client said she was angry, I had to use probing questions to further define her anger i. e. What or who is making you angry? What are they doing to make you angry? " I used open questions to fill in the background information i. e. " Can you tell me what your typical day is like now? What was your day like before the suicide attempt? " Finally, closed questions were used when I had the sense of the issue and needed clarification i. e. " so your son was transported to the hospital in an ambulance, and you followed in your car? " All questioning systems were utilized for maximal time and informational benefit. Use of Use of paraphrasing statements

Advanced practice is the use of advanced reflecting skills. The beginning of reflection for the client is the use of a paraphrasing statement. In my counseling session with the client, paraphrasing statements were used to sum up the client's statements and to see if I was interpreting their content. An example of a paraphrasing statement in the session was, " I understand that your daughters feel that you are the cause of your son's situation. "

This, of course, would be entwined or followed by a reflection of feeling or meaning phrase. Use of restatements or reflection of feeling statements

Meaning is the background against which the client's story is played, but it needs to be noticed and brought into awareness" (Young, 2001, p. 122).

When the issues are reframed from an outsider's perspective, the client sees the issues differently and feedback allows the caregiver the understanding of the client's problem. Like Plato's shadows reflected on the cave wall, when we have the advantage of other's viewpoints it helps to redefine our views.

An example of reflection of feeling statement in my interview is, " When your daughters says these things to you, it makes you feel guilty and as though you are a bad mother, is that correct? Reflection of meaning is the outcome of what the client's feelings engendered, and is included in the preceding sentence as the second half of the statement i. e. " bad mother" is the meaning behind the accusation. Use of clarification statements Clarification statements are useful for the caregiver to ensure that he has a grasp on what the real issue is for the client. Clarifying the real issues narrows down the problem into a few specific tasks and goals. An example of a clarification statement is, " I hear you saying that you are angry.

Who are you angry with? " Use of summarizing statements " Summarizing is the final reflecting skill among the building blocks" (Young, 2001, p. 130). A focusing summary was used in the client's second interview to refocus the conversation at the start of the interview. And example of the focusing summary used in the session was, " Last time you were here, we talked about your son's behaviour and how that was impacting your life. " A signal

summary during the middle of the session helps the client to know that the caregiver understands what has been discussed.

An example of this during our sessions is, " Before we discuss the issue of your daughters, let's just summarize what we've discussed so far about your son. You have tried to get your son to discuss his issues and he refuses. This refusal has come back to you in the accusation that you are a bad parent. You've always worked hard to put food on the table, so this accusation is especially frustrating. " A thematic summary was also used. A theme " is a pattern of content, feelings or meaning that the client returns to again and again" (Young, 2001, p. 132).

I used a thematic summary when I remarked to the client, " I see the issue of you working outside the home coming up again and again in conversation. It seems that working outside the house was something that the children resented. " Acknowledging nonverbal behaviours Client laughs and leans forward while saying things that are painful or could be considered inappropriate, " I'm so angry that he tried to commit suicide. " The client was tearful and laughing in the same train of thought. This would indicate the client is conflicted about her inner thoughts and her outward actions.

Helping a client discover possibilities for change " Motivational intervention" (Rollnick, Mason, & Butler, 1999, p. 190) is necessary. This is the act of giving the client the ability to look at why change would be beneficial to them, in their own words. An open ended conversation about why reframing her reactions to her son's behaviour would be beneficial or harmful was discussed. This conversation helped the client to determine that no harm

could come from letting “ go of (my) guilt” that had resulted from the son’s behaviour.

In addition, we discussed the notion that adult children are responsible for their own behaviour. The client agreed that change of cognition by the client could only happen by the client. However, her response to his behaviour can be changed if she allows herself permission to do so. The client identified her own available options, resources, and supports. It was difficult getting client to discuss her own reasonable options, resources and supports. I asked about different supports available in the community, at work, within the family.

The client could not verbalize any supports. However, on the second visit the client was able to discuss the help that she had received from a Native traditional healer in the past. She recognized this as a source that could be utilized in the future. Additionally, I assisted the client in allowing herself permission to accept help from her adult daughters. The client voiced that it was “ terrible that I would rely on them”. However, we discussed that the daughters needed to help the client so that they could gain understanding into her difficulties with the son.

My skill in helping a client commit to their own plan and goals strategies. The client must perceive me as a credible and competent professional (Young, 2001). The interaction between the counselor and client must be professional at all times to engender this respect. “ Perceptions of expertness lead to positive outcomes” (Young, 2001). The client is more likely to accept and commit to their goals if they perceive that an expert

helped them. In addition to a knowledgeable helping person, the client needs to define their own goals, and the ways of attainment so that they can have meaning to the client.

The client's own defined plans and strategies will ensure a higher level of commitment to the goals (Y. Applewaite, personal communication, 2004). Indeed, Rollick et al discuss that personal control is necessary for the client to be motivated to change (1999). The client defined her goals and in subsequent interactions we will discuss how she will be able to reach her goals. The client believes in her goals because she defined them with the use of summarizing statements. My strengths and weaknesses I believe that my strength as a therapist comes from the belief that people have a right to talk and be heard.

The belief guides me in my ethical decisions regarding nonpaternalism, nonmaleficence and beneficence for the client (Yeo and Morehouse, 1998). These guiding ethics help me recognize the value and individuality of each person I help. I find it very difficult to sit and listen to someone without giving advice. I always want to fix people and make their lives better. It's very hard for me to sit still and listen in a meaningful way when I don't like the client's choice of actions, or in this situation, feel that the client is being too hard on herself.

I just want to jump up and give her a hug and say, " cheer up! " I am very aware that this behaviour is improper in a professional relationship.

Advanced Counseling Methods That Were Used and My Rationale For Using Them Cognitive behavioural therapy was introduced to the client at the end

of the second session. The client seemed somewhat willing to dispense of blame and guilt for others actions. I was not particularly interested in the etiology of the client's belief systems, nor any other analytical therapy. Analysis takes too long for the same result, which is behavioural change (Young, 001). The client's son was coming home in two weeks time, so effective, fast therapy was indicated in this situation. Effects of My Specific Communication and Counseling Methods on the Client's Ability to Change The use of partial self-disclosure about my own teenager and his trials made the mother lower her defensive status with me. She had related that the caregivers in London had "blamed" her for the client's suicide attempt and subsequent muteness towards caregivers. It was important for the client to know that someone else had the same set of difficulties.

It ensured that the commonality of situation engendered a quicker trust response because the client knew no blame would be assigned her. Self-disclosure, while not universally recommended (Watkins, 1990), has demonstrably been shown in the evidence to "deepen client self-disclosure, and encourage expression of feelings" (Young, 2001).

Additionally, "clients have reported that self-disclosure by the helper is extremely valuable" (Knox, Hess, Peterson & Hill, 1997). We discussed the problems with working and trying to raise a family. The client was under no illusion that this was anything other than a therapeutic communication.

However, the empathy and nonjudgmental attitude towards the client ensured her confidence in sharing angers and fears. She even voiced that she "hated him for all he's putting me through". The client seemed to be embarrassed by this admission, as she said, "I've never said that to anyone.

Please don't tell anyone". The client was also reassured by the nature of confidentiality in the therapeutic relationship, of which the boundaries and responsibilities were reiterated when necessary. The client's second interview demonstrated that she felt more comfortable and was able to interact with the counselor more effectively.

She confided that she had considered that she was reacting maladaptively to the children's protestations of maternal blame. She had not considered this scenario in the previous interaction. The use of Cognitive Behavioural Therapy to effect change in the client's life would then be justified in future sessions. Rollnick et al (1999) believe that the client who is more receptive to change will require a skill intervention. CBT is essentially giving patients tools to cope with the feelings they are encountering inwardly by changing outward behaviour (Uphold & Graham, 2003).

The client's next counseling intervention will talk about her behaviour and how to change it by changing and reframing the cognition behind the behaviour. If the methods used produced a negative effect, what would you do differently next time? What is your rationale? There was no negative effect seen. However, if a negative effect were noticed, I would modify my counseling behaviour in the area where the negative effect was noted. For instance, if the client didn't respond to self-disclosure, I would immediately refocus the topic back onto the client's situation.

The use of self-disclosure is risky in that not all counselors recognize its use (Watkins, 1990). Were the desired goals achieved? If not, why not? The goals have not been achieved at the time of writing. The client has moved slightly

towards cognition of her ability to effect behavioural change. However, the client is contemplating change. She still needs the empowerment to move to a “ skills based intervention” (Rollnick et al, 1999) based on her stated strengths and goals. Adding to the resistance to change is the client’s strongly rooted belief that motherhood is the root of children’s behaviour forevermore.

The client believes that that her adult children’s actions reflect on her ability as a mother. The client’s adult daughters have further reinforced this belief by reiterating that the client has caused the adult son’s behaviour by her ‘ selfish’ actions related to full time employment, and not being at home ‘ being a mother like you should be”. Particular Challenges Faced and How I resolved these challenges The client was somewhat distrustful of health care providers because of the blame she felt that the London Mental Health Unit has assigned her.

The client was reluctant to talk about her difficulties. The client’s reluctance to discuss her personal life was resolved when she felt comfortable and in a safe environment. I discussed client- caregiver confidentiality. I also discussed with the client that she seemed to have the weight of the world on her shoulders. By using empathy, nonverbal techniques (indirect eye contact as to be nonthreatening; body positioning halfway towards her, but not intrusively close; leaning forward when she spoke, nodding), and partial self-disclosure the client relaxed and was able to confide her troubles. My Particular Strengths and Weaknesses in this Counseling Assignment I view the fact that I have a troubled teenager as a strength and a weakness. I am already aware of the lack of resources for teenagers in our area. I know

firsthand the frustration a single mother can feel when dealing with a teenager. I can display genuine empathy and caring for the mother.

However, it is very easy to put my child's situation and solutions upon this client's situation.

My goals, and my son's situation are very different from the client's goals and situation. I cannot lose sight of the fact that the therapeutic relationship only includes the client's needs and goals. In addition, I find it would be very easy for me to be consumed with the client's problems. I am aware of this tendency, so I am mindful of Frieda Fromm-Reichmann's (1960) stance that therapists must be like skin divers, able to go to the depths of a client's problems, but also able to surface when necessary (as described in Young, 2001, p. 52).

This will be my continued area of improvement. References Canadian Pharmacists Association. (2006). Compendium of pharmaceuticals and Specialties: The Canadian drug reference for Health Professionals. Toronto, ON: Author. Knox, S. , Hess, S. , Peterson, D. , & Hill, C. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long term therapy. *Journal of Counseling Psychology*, 44, 274-283. Rollnick, S. , Mason, P. , & Butler, C. (1999). *Health behaviour change: A guide for practitioners*.

Toronto, ON: Churchill Livingstone Inc. Uphold, C. R. , & Graham, M. V. (2003) *Clinical Guidelines in Family Practice* (4th ed. , p. 633-639). Gainsville, FL: Barmarrae Books, Inc. Watkins, C. Jr. , (1990). The effects of counselor self-disclosure: a research review. *Counseling Psychologist*, 18, 477-500. Yeo,

M. , & Moorhouse, A. (1998). Concepts and cases in nursing ethics (2nd ed.). Toronto, ON: Broadview Press. Young, M. (2001). Learning the art of helping: building blocks and techniques (2nd ed.). Toronto, ON: Merrill Prentice Hall Inc.