Development of Counseling Patients

Tara Prater, Lisa Sherfey, Louisa Bennitt, Angela Lafollette, and David Dirlam [i]

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	Beginning	Exploring	Sustaining	Inspiring
Personal				
Emotional State	VULNERABLE Shows high emotionality (nervous, fear of unknown, fidgeting, or tears). Inadequate self-care. Anxious and possibly guarded but ready to change with ability and willingness to engage in process. May express feelings about process and past therapy	DEPENDENT Smile more, fidget less. Discuss alliance. Report better relationship and interactions outside home. Show more self-care and self-disclosure. Show symptom relief despite reduced medications. Need support with coping skills, resistance to change, or the process.	POSITIVE Meet therapy goals with rare relapses. Enjoy work and family. Show less anxiety, more self-disclosure, confidence, insight, and problem-solving and coping ability. Need continued search for problem origins, progress signs, and use of coping skills.	CONFIDENT Help others (e.g., become a counselor) with specific knowledge of issues versus just giving comfort. Confident problem-solvers. Describe CBT. Share learning with others. Daily functioning has improved social interaction, tolerating change and failure, and emotional control.
Health	SYMPTOMATIC: Mention a health symptom or illness (weight, appetite, or smoking). Somatic complaints, frequent ER visits, multiple meds, physical complaints, missed therapy appointments. Begin work on negative thoughts. need assessment of physical, psychological, home, and work functioning.	SOMATIC: Discuss unmet needs with a somatic focus (identity based around being sick). Cannot distinguish depression, anxiety, and health issues. May need help with medical compliance (exercise, sleep, diet, meds), understanding and acceptance of problem and treatment.	PROACTIVE: Aware of problem source and alleviation. Less obsessive focus on sickness and thoughts about health; more physical activity and insight. May need help distinguishing physical from emotional issues, compliance with medical plan, and acceptance of problems/treatment	THERAPEUTIC: Use experience to make contributions (e.g., teaching, research, sports leadership). Find life emphases different from their problem. Use one field to understand another. Involved in life, self-care (sleep, exercise), physical functioning, illness management, and assistance access.
Physical Security	VICTIMIZED: Mention motive for therapy is abuse from any source, PTSD, deprivation, accident, or crime victim. May show bodily harm, social isolation, mistrust. fear, disclosure inhibition, startle responses, anxiety, excessive apologies, or guardedness. May need safety planning.	VIGILENT: Avoid loud noises. Mention anger, fear, mistrust, and nightmares, Foresee negative future. May show behaviors that threaten safety. Weak therapist alliance or ethical reporting may induce avoidance. Gradual exposure and planning for safety sometimes work.	MAINTAINING: Show understanding of trauma. Rate distress as tolerable (e.g., on SUDS scale[ii]). Spontaneously do what they used to avoid: more trust and self-disclosure, less fear and self-blame. Relate the cycle of abuse with their past choices.	PREPARED: Full understanding of abusive dynamics. Able to plan safety, take initiative, and independently change situations. Apply research in memory, thinking, and animal behavior. Show trust, self-esteem, and confidence in their ability to form healthy relationships.
Leisure	IMBALANCED: Too much or too little Leisure disrupts life (e.g., high-functioning and overworked, isolated, excessive sleeping, or self-medicating with alcohol or drugs). Lack knowledge of the importance of self-care, enabling behaviors, codependence, and balancing life demands.	INTENTIONAL: Mention voluntary leisure activities. Gaining insight about importance of self-care, work/life balance, and relationships (e.g., coping with others who may criticize). Need increased socialization and education about importance of and insight into selfcare.	STRATEGIC: Balance leisure on their own spontaneously. Alleviate chronic pain through leisure and self-care strategies. Show new perspective about time, less guilt involving selfcare. Identify costs of overwork and benefits of and barriers to work/life balance.	COLLABORATIVE: Use community groups and social media to help people work together (DBT, AA, Alanon, church). Mention stress less, fun activities and groups more. Internalize regular self-care routine, maintaining discipline despite obstacles. Understand and achieved work/life balance.

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Cognitive				
Creative Survival	HELPLESS: Homeless, without food, transportation, insurance. Financially stressed (but may conceal it), helpless, hopeless, and chronically stressed. Survival skills may not be functional (e.g., stealing) and their resilience may be good or bad thing.	HAPHAZARD: Have sporadic plans for solving chronic lifestyle issues and identify some resource assistance. May use express feelings through art. Respond to acknowledging their strength in survival efforts. Still need help extinguishing negative or substituting positive skills.	CONVENTIONAL: Apply experiential learning to new situations. Have more hope, stable food source, appropriate housing, less anxiety and financial concerns. Verbalize feelings. May have gained employment, but need support for healthy spending and exploring family dynamics obstacles	INNOVATING: Mentor others in more effective problem solving. Survival plan may include display and sales of arts and craft. May seek occasional support for maintaining skills like gaining insight into chronic issues, including responsibility and money management.
Understanding	ISOLATED: Express social awkwardness, low self-esteem, trouble fitting in, people don't understand them, everyone mistrusted. Possibly on autism spectrum, poor communication. May respond to social interaction, group referrals, validation of feelings aimed at making patient feel heard.	PERSONAL: Learn interpersonal skills (e.g., "I" messages), boundary maintenance, self-awareness, self-esteems, internal/external loci of control, barriers to feeling being heard (e.g., emotionally closed or weak communication skills). May have chronic social problems, poor relationships, delusions, or autism.	SYMPATHETIC: Consistently show and receive understanding. Chronic issues may recur, but trust, self-esteem, and socialization have improved. May have joined a group. May respond to communication skills teaching, role-playing, or "family of origin" and powerlessness discussions.	COMPASSION: Help others. Take responsibility for and fostering effective communication (e.g., communication research like Chapman's 5 love languages, ministry, counseling). Self-report of learning, achieved developmental changes, better mood, sense of belonging, getting job, and meeting emotional needs.
Liberty	POWERLESS: Report freedom restrictions, inability to change or guide their fate, and high levels of emotional distress. Show shame (especially sexual abuse), guarded, distrustful, withholding information. Describe the controlling person. Feel little control over themselves and environment.	HESITANT: Trust and self-disclosure build slowly. Need feelings validation, parental understanding (especially teens). Explore developmental or environmental causes of powerless feelings, why solutions seem difficult, personal resources, times of feeling powerful, and minimizing damage without situational change.	PROACTIVE: Regularly control situations strategically, assertive but accepting what they can't change (e.g., leave, persuade, apply lessons to new situations). Trust therapist; disclose abusive events; find outside support; learn about healthy relationships, boundaries, and decrease self-blame.	SUPPORTIVE: Have worked through past trauma, developed an internal locus of control, healthier relationships, improved mood, assertiveness in making positive changes in life, and insight into what they have control over and what they do not.

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Social				
Identity	DIFFUSE: Identity problems differ: professional, sexual (gender identification), life goals (especially family), health, acculturation, or community membership. May tend to people pleasing or co-dependent parenting. Express feeling ashamed or lost. Need help articulating their thoughts, feelings, and identity.	MORATORIUM: Describe their identity and how they see the world reacting to it. Identify organizations that help maintain former resources. Create plans. Identify patterns, sources of negativity or confusion, knowledge of problem, duration, and outcomes of struggling.	ACHIEVED: Find new directions and more autonomy. Resolve crises by accepting their enduring identities (sexual identity struggles include rejection, guilt, or spiritual issues). Establish, maintain, or change relationships and a support system without relinquishing values and goals.	ENABLING: Comfortable in discussing their identity, showing high self-worth and confidence. Able to assist others with the same type of struggle (e.g., Al-Anon).
Love	LONELY: Express loneliness, problems with persons at home or family. Feel disconnected from everybody, including spirituality, community, and support. Sometimes report marital problems, family conflict, depression, loneliness, people pleasing, feeling lost, lacking identity, and lacking sense of self-worth.	TESTING: Test changes in communication with important others, discipline strategies, strictness, relationship dynamics, development of social support or barriers, identity, self-worth, loss, grief, guilt, outcomes of choices, and sources of their sense of being loved or belonging.	CHOOSING: Understand problem source(s). Find some strategies that successfully decrease depression, increase self-esteem, produce better relationship choices, and avoid past destructive tendencies. May accept a loss but lack accurate perceptions or feel like a victim of circumstance.	GIVING: Build a community of their own and take personal responsibility for this. Express and show love to others not dependent on their response. Report positive relationships, finding a niche in life. Reconcile or cope with rejection.
Belonging	DISCONNECTED: Tell about being bullied, ostracized, devoid of community. Appear disconnected from their local culture.	ASSERTIVE: Become more assertive. Describe their place in the world. Address their issues sometimes with community help. Persist with administrators.	JOINING: Find a community that they fit in. Introduce themselves, have conversation. Know how to be likable. Make eye contact. Recognize smiles.	INVITING: Use artifacts or games as guides or reminders. Get out into and contribute to community. Create social media, self-help groups (AA, Alanon, church). Take personal responsibility for building community on their own.

[i] The dimensions add *emotional state* to the nine dimensions of fundamental human needs identified by Manfred Max-Neef (1989) *Human Scale Development.* David Dirlam interviewed Tara Prater, who in turn interviewed the other three counselors. The final summary was a collaboration between Prater and Dirlm.

[ii] SUDs refers to a ten-point scale used in clinical settings to identify a person's "Subjective Units of Distress."