COUNSELLING COURSE

1. Conditions facilitative of growth
    - Emotional support
    - Confrontation
2. Confidentiality, Dual Relationships
3. Boundaries
    - Sexual feelings in counselling (Self-Assessment)
    - Consequences of sexual abuse
4. Parallels between psychological and spiritual growth
    - Basic needs from a psychological development point of view
    - Moral development
    - Spiritual development
5. Some differences between men and women:
    - “Men barter relationship for sex; women barter sex for relationship”
6. Ethnic & other groups
7. Common single predictors of suicide, assessment of suicide risk
8. Training for differential diagnosis and referral
9. Helping the helper

References

HE SAID, SHE SAID

Poor Communication leading to Interpersonal Distance:

He tells her about her (using “You”statements).

She feels hurt, angry, etc. and gets defensive.

She tells him about him (using “You”statements).

He fells hurt, angry, etc. and gets defensive.

Good Communication, which can (not will) lead to Interpersonal Closeness

He tells her about himself (using “I” statements).

She has an opportunity to hear what he is saying about himself.

She tells him about herself (using “I” statements).

He has an opportunity to hear what she is saying about herself.

Improving Communication:

He tells her about her (using “You” statements).

1. She tell him about herself (using “I” statements).

or

2. She hears his statement about her *as if* it is a statement about himself.

EMOTIONAL SUPPORT

In the following items, it is to be understood that what we are interested in is ***what the helper's response communicates***, not in what he understands or in what he actually feels for the other person.

EXPRESSED EMPATHIC UNDERSTANDING

1. Is quite unable to hear and/or accept the feelings expressed by the other person. Imposes own ideas and/or feelings.
2. Subtracts noticeably from the other's feelings.
3. Matches/acknowledges the other's expressed feelings.
4. Goes beyond the other's expressed feelings, communicating some understanding of the feelings which the other has but has not been able to express.
5. Communicates a deep understanding and acceptance of the other person's feelings.

RESPECT

1. Communicates a lack of respect for the other person's feelings and potentials.
2. Fails to communicate respect for the other person's feelings and potentials.
3. Communicates respects for the other person's feelings and potentials.
4. Communicates respect and concern for the other person.
5. Communicates deep respect and concern for the other person. For example, his or her response shows that he or she really values and delights in the other person.

CONSTRUCTIVE GENUINENESS

1. Communicates to the other person that he or she is just playing a "helper" role, that he or she is just going through the motions as it were.
2. Sounds somewhat impersonal or "distanced" from the situation.
3. Sounds sincere but, beyond that, communicates little real involvement with the other.
4. Shares his or her own feelings as appropriate in such a way as to open up the lines of communication between him- or herself and the other.
5. Levels with him- or herself and the other in a way that is not judgemental.

FACILITATIVE SELF-DISCLOSURE

1. Rebuffs any attempts by the other to get to know him or her.
2. Responds to direct questions about him- or herself *as appropriate*, but doesn't volunteer any information about himself unless asked.
3. Volunteers personal information about him- or herself *as appropriate*.
4. Discusses personal feelings, beliefs and values *in whatever depth is appropriate*.
5. Allows the other person to become intimately acquainted with him or her.

HONESTY IN RELATIONSHIP

CONCRETENESS

1. Appears committed to keeping everything vague, abstract and/or anonymous.
2. Appears to be colluding in keeping everything vague, abstract and/or anonymous.
3. Appears willing to allow the other person to discuss personally relevant issues in specific and concrete terms.
4. Encourages the other person to discuss personally relevant issues in specific and concrete terms.
5. Can be counted on to guide the discussion in such a way that the other person may discuss, directly and completely, those issues of most concern to him.

CHALLENGE OF DISCREPANCIES

1. Fails to recognize obvious discrepancies between what the other person says and what he or she does.
2. Recognizes discrepancies between what the other person says and what he or she does, but fails to question him or her about it.
3. Questions discrepancies between what the other person says and what he or she does.
4. Frequently confronts the other person with discrepancies between what he or she says and what he or she does.
5. Can be counted on to confront the other person with discrepancies between what he or she says and what he or she does.

IMMEDIACY OF RELATIONSHIP

1. Tries to avoid any discussion of the relationship between him- or herself and the other person.
2. Accepts any attempt by the other person to communicate regarding the relationship between the two of them.
3. Responds to both content and feelings expressed by the other person regarding the present (counselling) relationship between the two of them.
4. Attempts to relate the other person's comments to the present (counselling) relationship as appropriate.
5. Directly and explicitly relates the other person's comments to the present (counselling) relationship as appropriate.

COMMITMENT TO CHANGE

1. Seems to accept the inevitability of the status quo.
2. Communicates the acceptability of the status quo.
3. Expresses belief in the other person's ability to make those changes necessary to resolve his or her present difficulties.
4. Expresses the expectation that the other person will make those changes necessary to resolve the present difficulties, and may offer to help him or her do so.
5. Communicates the expectation that the other person will make those changes necessary to resolve the present difficulties, and a commitment to helping him or her to do so.

SELF-AWARENESS

ACCESS TO FEELINGS

1. Avoids all reference to his or her own feelings.
2. Talks about his or her feelings as if they belong to someone else.
3. Seems to have some access to *how* he or she feels, but not much understanding of *why* he or she feels that way.
4. Shows reasonably good access to his or her own feelings and at least some understanding of *why* he or she feels that way.
5. Shows immediate and free access to his or her own feelings, and has a good understanding of *why* he or she feels that way.

DIFFERENTIATION OF FEELINGS

1. Seems unwilling to even try to differentiate among his or her feelings.
2. Seems willing to try to differentiate among his or her feelings, but *tends* to respond to everything in more-or-less the same way.
3. Often seems to be trying to differentiate among his or her feelings.
4. Seems to be actively involved in trying to differentiate among his or her feelings most of the time.
5. Clearly and consistently differentiates among his or her various feelings.

SELF-EXPLORATION

1. Actively and refuses to discuss issues that have any personal relevance for him or her.
2. Appears willing to discuss personally relevant issues, but only in an intellectual or detached way.
3. Appears to be emotionally involved in *discussing* personally relevant issues, but without exploring very much of the meaning that they may have for him or her.
4. Appears to be emotionally involved in *exploring* issues which have personal relevance for him or her.
5. Appears to be committed to exploring those issues which have personal relevance for him or her.

INTERNALIZATION OF RESPONSIBILITY

1. Shows little or no awareness that he or she contributes to any problems which may exist (e.g., sees him- or herself as a victim of circumstances).
2. Appears willing to consider the possibility that he or she contributes to any problems which may exist, but still tends to place most of the responsibility for them on factors external to him- or herself.
3.. Appears to have a definite desire to learn how he or she contributes to any problems which may exist, but seems to have little understanding of how he or she does so.
4. Shows *considerable* awareness of how he or she contributes to any problems which may exist.
5. Appears both willing and able to accept a realistic degree of responsibility for the extent to which he or she contributes to any difficulties which may exist.

STATEMENT OF LIMITS OF CONFIDENTIALITY

1. Confidentiality is important to me. However, there are certain legal limits on the extent to which the information that you provide can be kept confidential. In each of these cases, I will consider it my lawful duty to inform the proper authorities.

a. The law specifically requires that "A person who believes on reasonable grounds that a child is or may be in need of protection... or has reasonable grounds to suspect that [a person who is currently] a child... may have suffered abuse shall forthwith report the suspicion and the information on which it is based to a [Children's Aid] society."

b. The law requires that health care professionals report any of their colleagues where there are reasonable grounds to believe that he or she has sexually abused a patient.

c. The law requires that my records be made available (i) if I am served with a search warrant, or (ii) on a judge's order.

d. Counsellors have a duty to protect their clients from committing acts of violence against either themselves or others.

2. If you are or become involved with the court, and if the court knows that you are receiving counselling from me, I may be required to appear in court with the records of my contacts with you and may be required to reveal in court any information that I have in my possession.

I certify that I have read and understand the limits of confidentiality stated above.

Signed: _____

Date: _____

Witness: _____

DUAL RELATIONSHIPS

Therapists and their clients often come to like and respect each other, and sometimes they are even attracted to each other. In fact, when therapy is intensive, both positive and negative feelings may become an important part of the therapeutic relationship. Such feelings may be appreciated as part of the human condition, but they must never be *acted upon*, since nothing must be allowed to interfere with the therapy relationship. They should, however, be discussed in therapy when they arise, so that they can be used in a therapeutic way.

In fact, it is not even possible for a therapy relationship to evolve into one in which the therapist and his or her client are ”just friends," because there must never be even the remotest possibility of the therapist taking unfair advantage of the psychotherapeutic relationship. A similar concern prevents me from being able to enter into any kind of business or other relationship with you, no matter how rational or beneficial it may seem at the time. The fact is that dual relationships frequently lead to conflicts between the therapist's interests and the client's interests, and it is important that the client's interests never be compromised.

SELF-ASSESSMENT

Can you remember a time during a counselling session when you became intensely aware of your own body?

Can you remember a time during a counselling session when you became intensely aware of a client's body?

During a counselling session, has a client ever made a move that startled you?

Under what circumstances would you hold a client's hand?

Under what circumstances would you put your arm around a client?

Under what circumstances would you cradle a client's head in your lap?

Under what circumstances would you hug a client?

Has a client ever initiated a hug or a kiss that was unwanted by you? How did you handle the situation?

Have you ever hugged a client or been hugged by a client in a way that seemed to have sexual overtones for either you or the client?

Under what circumstances would you kiss a client on the cheek or forehead?

Under what circumstances would you have dinner with a client?

Under what circumstances would you not have dinner with a client?

Under what circumstances would you go to a client's home?

Under what circumstances would you agree to meet a client at a hotel or motel?

Under what circumstances would you enter a client's bedroom?

Has a client ever dressed in a way that made you feel uncomfortable? How did you respond to your feelings of discomfort?

Have you ever imagined what a client would look like if he or she were not wearing any clothes?

Did you ever think that a client may have wondered what your body would look like without any clothes?

Has a client ever talked about his or her sexual experiences in a way that you found exceptionally interesting or enjoyable?

Have you ever had erotic thoughts about a client or an erotic dream about a client?

During a counselling session, have you ever become sexually interested in a client, or sexually aroused? Did you make any effort to conceal your sexual interest/arousal? Did you make any effort to reveal your sexual interest/arousal?

Have you ever fantasized about sex with a client?

Has a client ever told you that he or she was sexually attracted to you? Has a client to whom you were sexually attracted ever told you that he or she was sexually attracted to you? Did whether or not you were attracted to the client make any difference in how you responded (or would respond) to these two clients?

During a counselling session, have you ever had any feelings of which you were ashamed?

Does a client's sexual orientation evoke any particular feelings in you? How did you respond to such feelings?

Have you ever been embarrassed by a client's disclosures?

Are you more likely to talk about sexual issues more with your female or male clients?

Are you more likely to touch your female clients or your male clients?

Under what conditions would you show a client how to put on a condom? Insert a tampon?

Under what conditions would you allow a client to partially disrobe during a session?

Under what conditions would you partially disrobe during a session?

Have you ever felt yourself physically attracted to a victim of abuse?

If your clients could read your mind, what thoughts or feelings would be most surprising to them?

What comment(s) could a client make about your looks that would be most hurtful? About your sexuality?

Have you ever felt jealous of a client's life partner, sexual partner, or dating partner?

If you could be guaranteed that you would suffer no negative consequences, would you ever consider entering into a sexual relationship with one of your clients? What factors would you take into account in your deliberations?

CONSEQUENCES OF SEXUAL ABUSE BY A "HELPER"

1. Ambivalence: Clients who have been sexually abused by a counsellor find themselves careening between two opposite sets of impulses: (a) to escape from the abuse and its lingering effects, to seek justice and restitution for the offence, and to try to get on with life, and (b) to deny the abuse or redefine it or fantasize that it was not abusive, and to cling and attempt to protect the offender. Such ambivalence can be very unstabilizing, because the victim is torn this way and that.

2. Guilt: The client mistakenly blames himself or herself for the sexual assault, and for "breaking the silence" when they eventually do tell what happened. This can be especially devastating when the abuser is "clergy," because the victim can also blame herself having done something to cause the clergyman's or clergywoman's "fall from grace." This is even further compounded by the fact that the client had been consulting a counsellor and "must," therefore, have had some psychological disequilibrium prior to the seduction.

3. Emptiness and isolation: The emptiness is experienced as "It is as if I don't exist without him." At the same time, the client experiences a sense of isolation, as if the client's identity has been degraded or altered to such an extent that he or she feels unable to rejoin the world of humans, as if he or she can no longer communicate with others. However much they may know intellectually that others have been through similar experiences, it feels as if they alone have been singled out. They may feel "dead" or numb or hollow inside, and they may find themselves waiting for death, convinced that there is no other way for them to re-enter the world of people.

4. Sexual confusion: Sexually exploited clients may respond with uncertainty about their own sexuality. They may feel, for example, that they are "only good for sex," or that they only exist to satisfy other people's sexual wants and needs. Their experience with the sexually exploitive counsellor seems to generalize to other relationships, with the result that they reenact with others the sexual behaviours previously experienced with the sexually exploitive counsellor. For others, sex -- and particularly casual and unprotected sex -- becomes a way to express their feelings of irrational guilt, as if to say "I am worthless and this is all that I deserve." Still others avoid sex altogether, or become so distrustful of others that masturbation becomes their only sexual outlet. And sometimes, the trauma is so

profound that the client has difficulty distinguishing sexual feelings and impulses from other affects and experiences.

5. Impaired ability to trust: When a counsellor decides to use the client's trust, not to help but to sexually exploit, the betrayal of trust can cause immense harm. The client is thrust into a world without kinship, a formless world in which most of his or her assumptions about relationships have to be questioned, suspended, and possibly abandoned.

6. Boundary disturbance and confusion of identity: When a counsellor uses the counselling process to satisfy his or her own needs at the expense of the client, this leads to a loss or impairment of the client's sense of boundaries, by which the client ordinarily defines himself or herself. This, in turn, tends to generalize to the client's refusal to acknowledge, respect and care for his or her own self, which can be expressed in such behaviours as difficulty making up his or her mind, having difficulty saying "No" to people, being taken advantage of, getting involved with people who hurt him or her, feeling as if his or her happiness depends on other people, taking on the moods of those around him or her, getting caught up in other people's problems, feeling responsible for how other people feel, having a hard time knowing or asking for what he or she wants, feeling ashamed of him- or herself, being overly sensitive to criticism, not knowing what to think or believe, loss of a felt relationship with God, etc.

7. Emotional lability: For the client who has been sexually abused by a counsellor, emotions tend to lose their reliability and customary patterns. Changes in emotion can be sudden, swift, and seemingly without any apparent reason. Similarly, emotional intensity may alternate with emotional numbness.

8. Suppressed rage: The client who has been sexually abused is most often angry, but this anger is often suppressed, only to re-emerge months or even years later. The reasons why the anger may be suppressed are many: Some are taught by their counsellor to suppress any anger; while some fear that, if anger were to be acknowledged, it would be so intense that he or she would be overwhelmed by it.

9. Increased risk of suicide: Of clients who have been sexually abused by a counsellor, about 15% will try to kill themselves and some will be successful. Depression, suicidal thoughts, and pressures towards self-mutilation and self-harm are frequent. Feelings of grief and guilt intensify these issues, with the result that they can come

to dominate the client's life.

10. Cognitive dysfunction, particularly in the areas of attention and concentration, frequently involving intrusive thoughts, unbidden images, flashbacks, and nightmares: And sometimes, these cognitive difficulties are part of a post-traumatic stress disorder.

BASIC NEEDS FROM A PSYCHOLOGICAL DEVELOPMENT POINT OF VIEW

Physiological Needs: Prerequisite

Psychological Needs:

1. Safety/Security
2. Love and Belonging
3. Competence/Mastery
    a. Autonomy
    b. Initiative
4. Intimacy
    a. Differentiation
    b. Integration
5. Identity
    a. Emancipation
    b. Sex role
    c. Value choice
    d. Vocational choice
6. Generativity
7. Integrity

MORAL DEVELOPMENT

Piaget's Stages of Cognitive Development:

According to Piaget, the child's cognitive development progresses through a series of four stages which he calls (1) Sensorimotor, (2) Preoperational, (3) Concrete Operational, and (4) Formal Operational, corresponding roughly to the ages from (1) birth to two years, (2) two to seven years, (3) 7 years to eleven years, and (4) eleven years and above. Growth needs to progress through these four stages in the order given, since the acquisition of each stage depends on mastery of the preceding stages.

Piaget's Stages of Moral Development:

In line with his general theory of cognitive development, Piaget suggested that moral development also proceeds on a stage by stage basis. Judgements concerning right and wrong -- judgements concerning what ought to be done, and why -- are limited by cognitive development in general. That is, the child cannot reason morally at a level beyond his ability to reason in general, and morality is not so much a function of what is done but of the reasoning that underlies the choice.

Kohlberg's Stages of Moral Development:

Elaborating on Piaget's theory of moral development, Kohlberg postulated a series of six stages in the development of moral reasoning, grouped into three moral levels, as follows:

Level 1: Pre-Moral Level

Stage 1: Punishment and obedience
(Action is motivated by fear of punishment)

Stage 2: Naive instrumental hedonism
(Action is motivated by hoped-for reward; the morality of the marketplace)

Level 2: Conventional Morality

Stage 3: Good-Boy/Good-Girl morality
(Action is motivated by desire for approval, avoidance of disapproval)

Stage 4: Law and Order morality
(Action is motivated by loyalty to authority, anticipation of honour/dishonour)

Level 3: Principled Morality

Stage 5: Morality of contract and democratically accepted law
(Action is motivated by concern for community acceptance; values are relative)

Stage 6: Morality of individual moral principles

(Action is motivated by personal integrity, self-respect, universal values)

SPIRITUAL DEVELOPMENT

Like psychological functioning in general and cognitive and moral reasoning in particular, faith has its own developmental stages. These stages of faith development tend to be organized around the individual's attempt to organize his or her experience through adoption of a world view which, in turn, is organized around certain master stories and centres of value that, over the years, have profoundly shaped human affections. Faith development involves cognition and morality, but at a broader level, it involves an attempt to grasp more fully the meaning of the whole of life. Fowler (*Stages of faith: The psychology of human development and the search for meaning*. New York: Harper & Row, 1981) describes seven such stages:

1. Primal Faith, up to about age 2
2. Intuitive-Projective Faith, from about ages 2 - 6, 7
3. Mythic-Literal Faith, from about ages 6, 7 - 12, 13
4. Synthetic-Conventional Faith, from about ages 12, 13 - ?

5, 6, 7.

There is a potential for crises of faith in the individual's movement from one to another of these developmental levels, and the pastoral counsellor should be familiar with and able to help his or her client's with the issues involved.

Another way to look at spiritual development is in terms of human maturity, as exemplified in the work of Robert Kagan. Kagan has described a series of developmental stages organized in terms of relationships. Each stage is defined by a development in self-other relationships in which there is both further differentiation from and integration with the other, both autonomy and inclusion. The stages are:

0. A lack of differentiation

1. The Impulsive balance

   (By about the age of two, the individual ceases to be his or her reflexes and, instead, becomes a person who has them)

2. The Imperial balance

   (The individual, now with a certain freedom, leans towards mutuality and belonging)

3. The Interpersonal balance

   (Relationship is a given; and satisfaction of the individual's needs must occur within the context of relationship. "I am my relationships.")

4. The Institutional balance

(Control replaces mutuality. “I am the I that has relationships.”)

5. The Interdividual balance

   (This is the stage that actually finds a mature balance between individuation and inclusion)

Depending where the individual is in this developmental process, he or she may need to be supported to become either more independent or more interdependent.

SOME DIFFERENCES BETWEEN MEN AND WOMEN

In a Different Voice, by Carol Gilligan

"Attachment and separation anchor the cycle of human life, describing the biology of human reproduction and the psychology of human development. The concepts of attachment and separation that depict the nature and sequence of infant development appear in adolescence as identity and intimacy and then in adulthood as love and work. This reiterative counterpoint in human experience, however, tends to disappear in the course of its linear reduction into the equation of development with separation. This disappearance can be traced in part to the focus on child and adolescent development, where progress can readily be charted by measuring the distance between mother and child. The limitation of this rendition is most apparent in the absence of women from accounts of adult development." Gilligan, 1982

According to Carol Gilligan, moral problems are problems of human relationship.

When Boundaries Betray Us, by Carter Hayward

Carter Hayward is an Episcopalian priest. Telling the story of her own psychotherapy, she challenges the validity of an ethic based on white male patriarchal logic, one which she feels exists at least partly to maintain male power and one which gives more credence to boundaries than to relationship: "as ethically precarious as an *uncritical* use of boundaries is, the fact is that, in hetero/sexist racist patriarchy, the boundaries -- that is, *bodily integrity* -- of most women, children, and oppressed men have indeed been violated, and our ethics must be grounded in a shared commitment to bring an end to the conditions that generate such violence.... Neither our good intentions and best efforts, nor the rules of our professions, are adequate criteria for our work. We cannot know either abstractly or individually what may be the best, most ethical direction for us to take in a professional situation. *Our ethics, to be genuinely compassionate, must be shaped in ongoing relational processes of dialogue, action, evaluation, and revision*." "For 'abuse' is not simply a matter of touching people wrongly. It is ... a failure to make right-relation, a refusal to touch people rightly. We ... are as likely to destroy one another and ourselves by holding tightly to prescribed role definitions as we are by active intrusion and violation...."

Boundaries and Relationships, by Charles Whitfield

"My briefest definition of spirituality is that it is about our relationships with our self, others and the Universe or God/Goddess/All-That-Is." "Berenson says, 'God is immanent within I-Thou relationships; yet entering into dialogue or relation also can provide a sense of a transcendent, absolute presence.'" "Each of these [intimacy and distance] is needed to keep balance and flow in the relationship, so that each can live

as a whole, separate and unique individual -- together. Healthy boundaries -- and boundarylessness."

ETHNIC AND OTHER GROUPS

Men
Women
Children
Adolescents
Young adults
Middle adults
Older adults
Singles
Couples
Families
Separated and divorced
Lesbians
Gays
The handicapped
Other minorities
In hospital
In prison
In the military
Anxiety and stress
Loneliness
Anger and aggression
Alcohol and drug dependencies
AIDS
Sexual dysfunctioning
Loss and bereavement
Depression
Suicide

COMMON SINGLE PREDICTORS OF SUICIDE

1. Depressive illness, mental disorder
2. Alcoholism, drug abuse
3. Suicide ideation, talk, preparation; religious ideas supportive of suicide
4. Prior suicide attempts
5. Lethality of methods
6. Isolation, living alone, loss of support
7. Hopelessness, cognitive rigidity
8. Being an older white male
9. Modelling, suicide in the family, genetics
10. Work problems, economics, occupation
11. Marital problems, family pathology
12. Stress, life events
13. Anger, aggression, irritability, 5-HIAA (lower levels of 5-hydroxyindoleacetic acid in the cerebrospinal fluid)
14. Physical illness
15. Repetition and comorbidity of Factors 1-14; suicidal careers

ASSESSMENT OF SUICIDE RISK

1. **Feelings of hopelessness** are the link between depression and suicide.
2. Statement of suicidal intent.
3. Serious family or interpersonal difficulties.
4. Preparation of a suicide note (The lack of a note does not mean that the person is not suicidal).
5. Development of a plan, availability of means, preparation for death, desire to conceal suicidal feelings from others.
6. Family minimization of the seriousness of a suicide attempt.

TRAINING FOR DIFFERENTIAL DIAGNOSIS AND REFERRAL

Psychosis masquerading in religious trappings

Religiosity, “religious” hallucinations, scrupulosity

Magic, exorcism, voodoo, poltergeists, reincarnations, and talking to the dead as deliria (acute brain syndrome), regression, defences, or non-supernatural phenomena.

Religious experience, religious conversion, spells, fugues, dream states.

Most espousers of the power of positive thinking are depressed.

Sociopath vs. Socially skilled; quiet schizoid vs. inhibited introvert; bland schizophrenic vs. frozen obsessive; intellectually deficient vs. boring intellectual

Grief, depression, joy, allergy, empathy, hysteria, emotional ability, emotional lability,

Delirium, toxicity (e.g., hallucinations of bugs, vermin, bizarre creatures)

Suicidal thoughts, suicidal threats, suicidal gestures, suicidal attempts (psychological pain with no end in sight)

Physical illness such as diabetes

Psychosomatic illness

Memory loss, headache, constipation, fatigue, sleep disturbances, eating disturbances (Depression?)

Family relationships (the client as emissary)

Psychopharmacology, and drug-induced iatrogenic illness (“Depression? What drugs are you taking? Anti-hypertensives?”)

Street drugs

Counselling-induced (iatrogenic) illness

Senility; depression; drug-dosage problems; etc.

Physical abuse

Sexual abuse

Post Traumatic Stress Syndrome

Multiple personality

HELPING THE HELPER

Signs of Daily Burnout

Mentally fatigued at the end of the day

Feeling unappreciated, frustrated, bored, tense, or angry as a result of contact(s) with clients, colleagues, supervisors, family, etc.

Experiencing physical symptoms such as headache, backache, upset stomach.

Demands seem greater than personal or professional resources

Tasks required on the job are beyond your capabilities

There seems to be no relief from job and other demands

Signs of "Secondary" Burnout

Disillusionment about being a counsellor/pastor/etc.; idealism waning, cynicism increasing.

General loss of interest in counselling - lasting for a month or longer

Pervasive feelings of boredom, stagnation, apathy, and frustration

Being ruled by schedule; viewing caseload impersonally; no longer attuned to clients as individuals

Loss of criteria by which to judge effectiveness of one's work

Inability to find refreshment in other aspects of one's life

Loss of interest in professional resources such as books, conferences

Intermittent lengthy (a week or longer) bouts of depression, irritation, or stress

CALLAHAN TAPPING PROCEDURES

Instructions:

1. **Recall the most emotionally-charged example of the situation.** If there is more than one emotion associated with that situation, you should:

   a. **deal with one emotion at a time**, and

   b. **finish with that emotion before going on with the next one.**

   As a general rule, you might focus on shock/fear, then pain/hurt, then anger/rage, and so on.

2. Muscle test while asking, "Do you want to get rid of the distress associated with this situation?" and "Is it all right to get rid of it now?" If the answer is, "No," the person is "psychologically reversed" (usually there is a limiting belief of some kind). You can temporarily disconnect the reversal by doing "reverse tapping" (Reverse tapping involves tapping the outer edge of the hand between the little finger and the wrist -- about where you would do a karate chop -- while saying, "I accept myself even though I have this problem," three times).

3. **Associate into the memory, or focus on the pain itself. Then step back out and rate the distress** (You can substitue any emotion) on the Distress Scale (Anyone at the 10+ level can expect to feel worse before they feel better).

THE DISTRESS SCALE

10+	I feel numb.
10.	The distress is as bad as it could be. I can't stand it. It puts me in a panic.
9.	The distress is almost intolerable.
8.	The distress is very severe.
7.	The distress is severe.
6.	The distress is very uncomfortable.
5.	The distress is uncomfortable, but I can tolerate it.
4.	The distress is noticeable and bothersome, but I can deal with it.
3.	The distress is slight, and I have it under control.
2.	I am rather calm and quite relaxed, and feel no particular distress.
1.	I am perfectly calm and relaxed.

4. If the distress is severe, begin tapping before associating into the memory again.

5. **Associate into the memory again and concentrate on being in it, just as if it were happening right now, while carrying out the tapping procedure.** Replay it over and over again -- from the initial shock until you are okay again. If the energy keeps moving around (e.g., the submodalities of the experience shift), keep tapping until it stabilizes. If you do a tapping point and there is no negative energy on it (e.g., nothing happens), then skip that point the next time around on that emotion.

6. **Reduce the emotional charge to a rated one, two or three, for each emotion separately for each memory.** It doesn't all have to be done in one fell swoop. Cycle through the procedure until you have dealt with each of the negative emotions associated with the distressing memory.

The Tapping Points

1. Cheekbone: On the top edge, just beneath the eyes, close to the nose.
2. Armpit: On the tips of the ribs opposite the nipples (or, for women, about the middle of the bra strap).
3. Eyebrow: Where it meets the nose.
4. Collarbone: The K27 point, the indentation just under the two bony ridges near the midline of the body, on the right side of the body.
5. Pinky: On the inside edge of the right pinky, out towards the nail.
6. The Gamet Point: The indentation just proximal to the knuckles of the pinky and ring fingers. You can switch hands on this one during the tapping, if necessary.

- tap with the eyes open.
- tap with the eyes closed.
- tap with the eyes looking down to the right (Note: Just the eyes; not the entire head).
- tap with the eyes looking down to the left.
- tap with the eyes circling smoothly clockwise.
- tap with the eyes circling smoothly counter-clockwise.
- tap while humming a tune out loud.
- tap while counting to forty by twos.
- tap while humming a tune out loud.

If the emotion on the memory does not reduce as expected, it just means that the client keeps slipping into "psychological reversal." In this case, have

the client rub the upper left chest about midway between the sternum (breast bone) and the armpit, to suppress the reversal until the procedure can be completed.

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