



The Premium Counselling Relationship Manual



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Introduction

Who is this manual for?

This manual is for people who have had no formal training in counselling but wish to learn the necessary components to establishing an effective counselling relationship. It will be useful for anyone who is involved in counselling people with a mental health problem.

What is the aim of this manual?

This manual aims at providing counsellors with information about the basic skills required in counselling in a practical and simple to understand format. It is meant to accompany the Healthy Activity Program (HAP) and Counselling for Alcohol Problems (CAP) manuals for counselling patients with depression and harmful/dependent drinking in primary care settings.

Who developed this manual?

This manual has been developed by the PREMIUM team as part of a five year project that seeks to develop and evaluate culturally appropriate psychological treatments for two priority mental health conditions – depression and harmful/dependent drinking - that can be delivered by lay counsellors in primary health clinics.

How is this manual structured?

The manual has six separate chapters. The *first chapter* presents an introduction of what counselling is and is not. This chapter also highlights how counselling is different from a friendly chat. The *second chapter* describes the key qualities and skills required to establish an effective counselling relationship as well as the different styles that may be adopted by a counsellor. The *third chapter* illustrates the key ingredients that help in creating the right conditions for getting started specifically focusing on the preparations required before the counselling session as well as introducing oneself to the patient and providing information about the confidential nature of the relationship. It also includes guidelines for home visits and the different ways the telephone can be used for counselling. The *fourth chapter* contains specific guidelines to help a counsellor assess and manages suicide risk as well as patients experiencing personal crises. The *fifth chapter* acknowledges the importance of family and friends in the patient's life and highlights key principles underpinning their involvement in counselling. The *last chapter* presents overarching elements required to become a more effective counsellor and covers the critically important skills on how to keep contact with patients to ensure treatment completion, supervision and referral guidelines, documentation procedures to maintain optimum standards and attention to the needs of counsellor by maintaining boundaries and preventing burnout.

Each chapter within is divided into learning objectives, content and a summary. A number of salient points are emphasised within the text and key concepts are illustrated with the use of case examples and scripts.

Material in some of the sections in this manual are based on previously published material from Velleman, Richard and Aris, Sarajane (2010) *Counselling and Helping: Psychology in Action*. London: Wiley Blackwell / British Psychological Society; and Velleman, Richard (2011) *Counselling For Alcohol Problems*, 3rd Edition. London; Sage (Counselling in Practice Series).

Chapter 1

An Introduction to Counselling

Learning Objectives

In this chapter, we will learn:

- What is meant by counselling?
- What is the difference between counselling and a friendly chat?

CONTENT

WHAT IS COUNSELLING?

Counselling involves helping and guiding patients in resolving their problems through an interactive learning process.

Counselling focuses on empowering people to overcome difficulties, to take control over their own lives, and to learn how to make the changes that they want for themselves and their futures.

Sometimes the term counselling is used to describe the advice given by experts to guide people in a specific area. For example, lawyers are sometimes known as “legal counsel”. Vocational Counsellors advise students about what subjects to take, what careers to follow. Financial counsellors teach people to use their money wisely and to repay loans. This is not the type of counselling that we will be doing.

Counselling is not about giving advice or telling patients what they should or should not do. It is often tempting to do this, because sometimes we are sure that we know what the patient should do – we will often feel that we know exactly what patients should/must do in order for them to start or continue to change. The temptation can be very strong to say ‘*If I were you, I’d do...*’ or ‘*what you’ve got to do is ...*’

However, patients will be far more likely to change, and this change is far more likely to be maintained, if they decide to make the change, and if they decide what that change is going to be. Therefore, counselling is about working with patients to develop a relationship that empowers them to make the changes they want to make.

Counselling includes using specific skills and abilities to develop a helping relationship that is:

- Based on understanding a patient’s mental health problems from his or her point of view and
- Focused on supporting the patient to take whatever action is needed to solve this problem

Counselling does not include:

- Telling patients what to do
- Making decisions for patients
- Judging patients as good or bad people
- Preaching or lecturing to patients
- Making promises that you cannot keep
- Imposing your own beliefs on patients

HOW IS COUNSELLING DIFFERENT FROM A FRIENDLY CHAT?

Table 1: Difference between counselling and a friendly chat

COUNSELLING	FRIENDLY CHAT
Expected to be confidential ¹	Not expected to be confidential
Focused, specific, goal targeted	Not focused on a specific goal
Helping patients find their own solutions	Advice-giving
Counsellor does not judge or take sides	Friends may be judgmental or take sides

Unless permission is obtained to share or under exceptional conditions such as a high suicide risk (*Chapter 4*)

COUNSELLING SKILLS

There is nothing magical about counselling skills. It is true that counselling does indeed involve certain skills and can involve professional training but a great deal of competent counselling is practised by people who have developed their skills through experience, reading, and sharing their ideas and concerns with others. The key is not primarily a person's qualifications; it is the skills and personal characteristics they utilise in building the counselling relationship.

Basic counselling skills are a necessary foundation for providing specific psychological treatments for people with depression and harmful drinking. This part of the manual will guide us in acquiring these skills to develop the counselling relationship. The additional steps needed to provide specific help to people with harmful drinking or depression problems will be dealt with in subsequent modules.

SUMMARY

- The counsellor works with the patient to develop a relationship that empowers them, so they can feel responsible for the changes they will have to make.
- The counsellor's task is not to tell patients what they should do.
- Counselling is different from a friendly chat or advice giving.
- The aim of counselling is to enable someone to take more control of their own life;
- Though there are personal characteristics that are needed to become a good counsellor, most of the skills required can be acquired through training and supervision

Chapter 2

An Effective Counselling Relationship

Learning Objectives

In this chapter, we will learn:

- What is meant by an effective counselling relationship?
- What are the key skills for developing an effective counselling relationship?
 - What are the different styles of counselling?

CONTENT

WHAT DO WE MEAN BY AN EFFECTIVE RELATIONSHIP?

New patients often arrive feeling anxious and negative about themselves and worried or uncertain about their first appointment with us. For many patients, seeing a counsellor in the clinic will be the first such experience of their lives and thus they may be unsure why they have been asked to see the counsellor and unclear about their role. They may be thinking, “Who is this person and why do I need to see him/her?” Our job as counsellors is to develop trust and engagement and through that, help reduce such anxious thoughts so that instead the person is thinking: *‘What a relief to talk to somebody’*; *‘She seems to understand me’*; *‘He seems to know what he’s talking about’*. If we can successfully show our patients that we are people who can be trusted, who will take them seriously, who will listen to and understand their problems, doubts, fears, and hopes, and who will help them with the problems for which they are seeking help, they will feel positive about seeing us, and will be more likely to engage with the counselling and obtain the most benefit from it. All of our work as counsellors needs to be done collaboratively in a partnership with the patient.

THE KEY SKILLS FOR EFFECTIVE COUNSELLING

The key qualities of an effective counselling relationship include:

- Counsellor and patient working as a team
- Goals, activities and possible solutions are planned collaboratively/together
- Counsellor encourages the patient to actively participate in the treatment process
- The patient feels valued and understood by the counsellor
- The patient realises there are decisions he/she can make to improve his/her situation and is helped to make these decisions

We communicate the possibility of trust and understanding by how we act towards our patients. We start to build trust in the counselling relationship by demonstrating some important qualities (i.e. warmth, empathy, and genuineness); by what we say and the way we say it. Let us see what each of these qualities means.

Figure 1



Warmth

Patients need to see us as being open and friendly. This conveys to the patient that he/she is worthy of respect and important to the counsellor and not 'just another patient' in the day's schedule. It also expresses our willingness to 'be there' for the patient.

The expression of warmth in a culturally appropriate way encourages patients to openly discuss their problems and explore possibilities for change in behaviour. The appropriate expression of warmth differs in different settings. For example, reaching out and laying a hand on the patients arm, while acceptable from a counsellor of the same gender, will be inappropriate from an opposite gender counsellor.

How to practice this quality with the patient:

- The way we greet a patient can show warmth – *“Hello, I am glad you could come today”*, accompanied by a smile (not as if she/he was simply the 10th patient you were seeing that day).
- The tone of voice can also be an important component of expressing warmth
- Getting up from our chair when patient comes in the counselling room and offering him/her a seat can be a good expression of warmth.

Empathy

Empathy is: 'the ability to experience another person's world as if it were one's own'. It involves

- Understanding the feelings and experiences of the patient from his/her point of view (i.e. "seeing the world through his/her eyes")
- Setting aside our own beliefs, attitudes, judgements when doing so is helpful to experiencing the patient's world
- Communicating this understanding to the patient

Empathy is not the same as sympathy. Sympathy implies a feeling of recognition of another's suffering and responding with pity while empathy is actually sharing another's suffering, if only briefly, whatever the nature of that experience. Empathy is often characterized as the ability to "put oneself into another's shoes".

How to practice this quality with the patient: Identifying a patient's emotions accurately and reflecting these emotions back to the patient are the key skills involved in empathy. We can practice our skills of empathy by reflecting our understanding of the patient's thoughts and emotions back to the patient and checking with them whether we have got it right. You will also learn more about this in the section on reflecting, below– here are a few examples to get you started:

1) Patient: *'If my parents ignore me then I just cannot tolerate it - I start throwing things and abusing them'*

Counsellor: *'You seem to get really angry when you are....'*

2) Patient: *'When I lost my job I cried a lot and I was just not feeling good. I spent most of my days in bed'*

Counsellor: *'It sounds like your job was really important to you and it was a great loss to you to be without it'*

NOTE: When practicing these qualities with family or friends, remember that as a counsellor, we are in a different role from being a friend and must keep in mind what we learnt about this in *Chapter 1*

Genuineness

A genuine person is one who is himself/herself and does not put on an act simply because one is a counsellor. Genuineness does not mean that the counsellor always expresses all their feelings. The aim is NOT to share every thought or feeling, in order to be genuine – the aim is to only say things that might be helpful to the patient and to ensure that what we express is real and honest.

How to practice this quality with the patient: Here is an example of responding in a genuine manner to what the patient says. You can practice similar responses.

Patient: *‘I am so glad to have found a counsellor like you. You seem to understand me so well. I am already feeling much better.’*

Counsellor: *‘I am as happy as you are to hear you say this. I am happy that I have been helpful - yet, I do think we still have more work to do together.’*

Once we have understood the types of qualities that promote an effective counselling relationship, let us look at the skills you can use that will help you build such qualities in your relationships with your patients? This is illustrated in *Figure 1*.

- Demonstrating acceptance
- Listening, and showing we are listening actively, and engaging with the patient;
- Reflecting both the verbal and emotional content of what has been said;
- Questioning in an appropriate way;
- Allowing silences;
- Providing affirmations or endorsing the patient's understanding of their problem;
- Summarising by expressing briefly and simply the difficulty the patient has described;
- Asking for feedback: asking the patient whether or not we have understood his/her experiences;
- Providing reassurance and hope.

Each of these skills is described in detail, below:

Demonstrating acceptance

Accepting our patients is one of the key skills for developing effective counselling relationships. Many patients are taunted or blamed for their way of thinking or behaviour by family and society. Due to this, a patient may try to hide these aspects of their thinking or behaviour from us. Acceptance by us of all aspects of the patient's thinking and behaviour in a matter-of-fact, non-judgmental manner can help a patient express their thoughts freely in the counselling session. It also can help the patient improve his/her self-acceptance and self-esteem.

Listening skills

It is important that the patient knows we are listening to what they have to say. Effective listening involves the following:

Non – verbal behaviour

- Maintain eye contact in a culturally appropriate way
- Demonstrate attention, e.g. nodding, leaning towards the patient
- Minimise distractions, e.g. telephone, noise
- Avoid doing other tasks at the same time e.g. checking our diary for the next appointment

Verbal behaviour

- Encouragement, e.g. “Mm-hmm”, “Yes”, “really”, “aha” (these are often termed ‘minimal encouragers’)

- Acknowledge the person's feelings, e.g. *"I can see you feel very sad"*
- Do not interrupt the patient unnecessarily
- Ask questions if we do not understand
- Do not take over and tell our own 'story'
- Repeat back the main points of the discussion in similar but fewer words to check we have understood the patient correctly

Listening also includes allowing for silences. Some people experience silences during a conversation as awkward and uncomfortable. But silence in the counselling session can have the following benefits:

- Gives a patient time to think about what to say
- Gives a patient space to experience their feelings
- Allows a patient to proceed at their own pace
- Gives a patient freedom to choose whether or not to continue
- Provides a counsellor time to absorb what the patient has said before providing an appropriate response

So, the counsellor can be flexible in responding to silences, allowing them to continue if they serve a helpful purpose at that moment of the session.

Reflecting

Reflecting means acting like a mirror. It helps in checking out our understanding of what the patient is saying and shows that we recognise its meaning for the patient. If we want to achieve and communicate empathy, we also need to check that the underlying emotions are also understood. This is done by:

- Listening for both verbal and non-verbal communication of feeling
- Reading body language and reflecting what we see if feelings are not verbally expressed

Here is an example

Counsellor: *You've told me that you're concerned about what you'll feel like after the operation to remove your uterus.*

Alisha: *Yes, I mean all sorts of complications could set in, but ... well, will I look ugly, you know to my husband, you know, err, ... will he find me ugly ... Will it affect me in any other way ... you know, you hear so much about how removing the uterus can affect women - they get weak and tired ... will this, this operation have that effect on me...?*

Counsellor: *It seems to me that you are concerned if you will be the same after the operation and whether your husband will still find you attractive.'*

Alisha: *Well, yes that's it ... what is going to happen to me?*

Counsellor: *And not surprisingly, I also hear a lot of fear in your voice...*

The counsellor uses both the content of what Alisha says and the way in which Alisha says the words as a basis for her reaction. Often the tone of voice, or the way the person fidgets or looks, can reveal as much as (and sometimes more than) the words that are used.

Questioning skills

In the course of counselling, we will find it necessary to use questioning to help us understand the patient's experience, assess the nature of the problem(s), and work together. There are two basic types of questions:

- Open-ended questions: These are very useful in inviting the patient to talk. They are questions that cannot be answered in a few words, hence they encourage the patient to talk and give maximum information, and e.g. *what brought you in here today? Could you tell me more about that? Do you have an idea about why this keeps happening? How does that make you feel?*
- Closed questions: These are questions that can be answered in a few words, they help focus an interview and obtain specific details, for e.g., *how much did you have to drink when you last had an alcoholic drink? Did you tell your wife you had a drink yesterday? Are you ready to stop doing that? Does your husband understand what you are going through?*

In general, when we ask mainly open-ended questions, the patient will end up speaking more than us, a sign that the session is going well; if we ask more closed questions, the patient may tend to offer brief answers and we will do most of the talking — a sign that the questioning style needs to be altered.

Providing affirmation

Affirmation is the expression of sincere appreciation by us of the patient's efforts and strengths in coping with his/her life challenges. Affirmation is an effective way of communicating a supportive and caring attitude. It is similar to when a parent encourages a child by saying *well done* or *you have done a great job*.

Affirmation can have be beneficial in number of ways

- Strengthening the counselling relationship
- Encouraging self-responsibility and giving the patient a feeling of being capable and in control
- Improving self esteem

Examples of statements that convey affirmation:

- *I appreciate the effort you have made to see me today despite how low you are feeling*
- *It is great that you recognize the risk and want to do something before it gets more serious*
- *You really have some good ideas of how you might solve your problem*
- *You have taken a big step today and I really appreciate it.*

Summarizing and asking for feedback

There are two different types of summaries that we make:

- 1) The summaries that are offered during the counselling session,
And
- 2) The detailed summary, offered at the end of the counselling session.

Summaries offered during the course of the session help us to keep our focus on the important areas in counselling and also to make transitions to other relevant topics. An important part of summarising is asking for feedback to assess whether we have understood the patient's problems accurately.

Examples of summarising during the session:

- *So in the past few days, you have been feeling frustrated that your child has been disobeying you. You have tried a number of different ideas to gain his cooperation but none seem to be working. Is that correct?*
- *So, what you have told me is that you are concerned that your health problems may be related to your drinking too much and that you are also worried about the effect it has on your performance at work as well as the financial strain it is causing you.*

You have described to me the effect your stress at work has had on your health, relationships at home and financial situation. Now you would like to get some relief from all your problems, is that correct?

End of session summaries are longer summary reflections of what has been discussed in the session and the plan that has been mutually agreed upon until the next session.

Example of end of session summary:

- *Today we have spoken a lot about the amount of responsibility you feel towards your family. We have looked at ways to help you cope with the situation and people who may be able to help you with all that you have to do. We have discussed how you may approach these people for help. In the next session we will look at whether these methods of coping have been useful and if they have reduced the stress you feel.*

Providing reassurance and hope

Reassurance is a way of giving patients courage to face a problem, or confidence that they are pursuing a suitable course of action. Also, giving them hope that together we will find a solution to their problems is essential to build a trusting relationship.

Example: You have already taken a step towards getting well by coming to see me. As I learn more about your problems, together we will think about possible ways to deal with these problems so that you will feel better and do the things you want you do.

THE DIFFERENT STYLES OF COUNSELLING

It is important to always be collaborative in our counselling and there are different ways that we can do this. Generally, counselling approaches can be grouped into two major styles:

- One of them is more active, where the counsellor may make suggestions, and may sometimes teach the patient certain skills or techniques, which will help them to take appropriate action;
- The other is less active and more discussion-based, where the counsellor mainly seeks to encourage and support the person to better understand their problem and, based on this better understanding, to choose an appropriate action.

We can illustrate the styles by reference to some case examples:

Indira who feels lonely and sad realises through counselling that she would feel better if she tried to make new friends. However, she says she is very shy. She gets anxious meeting new people and avoids it if she can; even with people she knows well she rarely initiates conversation. The counsellor suggests a set of routines that Indira can use whenever she starts to feel anxious - routines which reduce the stress and enable her to function in the social situation. She teaches Indira how to initiate conversations with strangers in shops and restaurants and role plays with her as she practices these techniques. Essentially, she guides Indira to practice and develop more effective social behaviours. Over six months, Indira becomes more confident and is pleased to begin a more active social life.

Another counsellor is working with Prashant, who has the same problem as Indira. Rather than training Prashant in acquiring and using new skills, this counsellor encourages Prashant to discuss possible situations where he may meet new people and how he may want to go about initiating a conversation with them. The counsellor discusses with Prashant what may interfere in his carrying out the plan and how he may try and overcome these barriers. Together, Prashant and the counsellor develop a plan of how this may be done. After five months, Prashant stops coming to the counsellor - he feels he is making enough progress on his own.

It is not difficult to identify the first approach as more active and the second as more discussion-based. Notice, though, that both approaches are collaborative (they are used with the patient, not imposed on the patient), and both produced positive results. Notice also that we are not saying that one style is 'better' than the other – as counsellors, we need to be skilled in using both styles.

We need to try to match our style with the patient's needs. Patients may become frustrated with more discussion-based strategies when they feel the need for more active help; and equally patients may feel that their counsellors are encouraging them towards action too much when what they really want is some space to reflect.

Commonly, we will find ourselves moving between counselling styles, both with different people and with the same person on different occasions. The skilled counsellor is one who is able to make effective use of the different styles of helping according to the needs of their patients. But whichever style we are using, we need to work with our patients, to empower them to take control of their lives and not dictate to them what is good or bad for them.

There are some situations when patients may find it difficult to take their own decisions and carry out the agreed-on decisions. Patients suffering from moderate to severe depression may be in this position and this may be due to various reasons like low levels of energy, sad mood, reduced hope and optimism as well as difficulties in attention and concentration. In such situations, it may be useful for us to take a more active role until the patients symptoms reduce to a level where he/she can participate more actively in the counselling process.

SUMMARY

An effective counselling relationship includes:

- Counsellor and patient working as a team
- Goals, activities and possible solutions are planned together
- Counsellor encourages the patient to actively participate in the treatment process
- The patient feels valued and understood by the counsellor
- The patient realises there are decisions he/she can make and is empowered to take charge of his/her life.
- Warmth, empathy and genuineness are very important qualities for effective counselling
- Other important skills which we learned include
 - Demonstrating acceptance
 - Listening, and showing we are listening actively, and engaging with the patient;
 - Reflecting both the verbal and emotional content of what has been said;
 - Questioning in an appropriate way;
 - Allowing silences;
 - Providing affirmations or endorsing the patient's understanding of their problem;
 - Summarising by expressing briefly and simply the difficulty the patient has described;
 - Asking for feedback: asking the patient whether or not we have understood his/her experiences;
 - Providing reassurance and hope.
- Two different styles of counselling are Active (counsellor takes more active role) and Discussion based (counsellor encourages patient to generate discussion based solutions)

Chapter 3

Creating The Right Conditions For Getting Started

Learning Objectives

In this chapter, we will learn:

- How to prepare ourselves for the counselling session
- How to greet the patient and introduce ourselves
 - How to talk about confidentiality

CONTENT

PREPARING FOR THE COUNSELLING SESSION

Before we begin a counselling session, there is a checklist of things we must be ready with. These are:

- All the material that we will need during the session which includes:
 - The patient booklets for [depression](#) and [alcohol problems](#) (described in Healthy Activity Program and Counselling for Alcohol Problem manuals)
 - Hand out for significant others for [depression](#) and [alcohol problems](#) (described in Healthy Activity Program and Counselling for Alcohol Problem manuals)
 - Clinical record form for [depression](#) and [alcohol problems](#)
 - The daily register for [depression](#) and [alcohol problems](#)
 - Plastic folder with a label for the clinical record form
 - Box file to store the forms according to disorder (i.e. depression or harmful/dependent drinking)
 - Digital recorder with charged batteries
 - Mobile phone to record appointments
- If we have seen the patient at an earlier session, we need to read through the patient's record including any comments made after the previous session, homework assigned and any major issues that had come up.
- As far as possible, the chairs should be placed in position so that we are facing one another at an angle with adequate distance between us. It is helpful if there is no furniture or desk between us.

GREETING THE PATIENT AND INTRODUCING OURSELVES

We need to put patients at their ease, especially at the start of their first appointment.

- Begin with greeting the patient with a warm smile.
- Offer the patient a comfortable seat.
- Ask the patient his/her name and the language he/she is comfortable speaking in.

With new patients, we introduce our name and what our role in the clinic is. For example, we may say:

"I am working as a counselor in this clinic. I've received training in providing counselling for patients with stress related problems. I work with supervisors, who have been trained by experts in this field. They will supervise my work. We will be meeting for approximately XX sessions for about 30-40 minutes each time. If you agree, I will visit your home for these sessions at a time that is convenient for both of us. However, if you prefer, we can also meet here in the clinic where you can combine a visit to the doctor and where we can talk in private and with no disturbance.

In this treatment, we will be working together as a team Thus, your participation as an equal team member is very important."

For patients who have a phone, you can add:

"If for any reason we cannot meet in person, we can also have a session over the telephone, or I could come to another place to meet you if you wanted – someone else's house maybe, or some other place where you feel happy to meet such as the temple or your church. I may call you on the telephone to ask how you are doing. Is this ok?"

TALKING ABOUT CONFIDENTIALITY

Patients may be concerned that we will let other people know what they have told us and what has been discussed during the counselling sessions. Patients are often concerned about disclosure to a member of their family, their neighbours or to their employer. So patients need to be assured that the details of what they tell us in confidence will not be passed to family, neighbours or employers.

However, sometimes patients will reveal things that raise our concerns about the safety of the patient or other people, or breaking the law. For example, a bus driver may reveal that he has an alcohol problem and that he frequently drives a school bus whilst intoxicated; or a 30-year-old woman may tell us that she is going to attempt suicide by consuming sleeping tablets that she has stashed away at home. *The basic rule* in these situations is that issues such as these must always be discussed within supervision: the decision to pass information to others outside of the counselling session should *never* be made by the counsellor alone. It may be necessary to speak to your supervisor over the phone, in case the situation is urgent. In addition, if we think that we may want to share this concern with a family member (or significant other); it is good practice to get agreement from the patient to do this.

(A Significant Other (SO) can be any person in the patient's life who plays an important part in the patient's emotional wellbeing and is ready to participate in the counselling treatment to help the patient overcome his/her problems. Most often, a SO is a close family member but sometimes a SO can be a friend or a well-wisher, such as a caring neighbour. In *Chapter 5* we will learn how to involve a SO in counselling)

When talking to patients about confidentiality, we must discuss the following:

- Patients should always know that we work as part of a study team and our work is supervised. So, we may need to frequently discuss what the patient has told us with our supervisors,
- In addition, there may be situations (like those described above) where the safety of the patient or others is at risk. At such times, we will not maintain confidentiality and will discuss with the patient about speaking to other concerned people.
- Counsellors, like doctors, may be required by law to disclose information to a court. On rare occasions under certain situations a judge can order helpers - including counsellors - to disclose what was said during a consultation.

This is what you can say to patients in the first session:

'What you tell me here will remain confidential. But there are few things I need to say about confidentiality.

***First,** I have a supervisor with whom I discuss my work so I may need to discuss what you tell me with my supervisor.*

***Second,** I am also a member of the team here, and I may also need to tell others in the clinic such as the doctor about what we discuss so that we can help you better. I will speak to you first before I do this.*

***Third,** in order to ensure you and others are safe, it may sometimes be important to share what you tell me with a family member or someone close to you. I will always discuss this with you before I do this.'*

Tape recording sessions

Using the digital recorder to tape sessions is important for supervision as well as for us to review our own tapes in an effort to improve our counselling skills. The patient will be informed about this by the health assistant and their consent taken. However, before every session, it is important to ask the patient if it is ok to switch the recorder on. Some patients may express concern about having confidential personal information recorded. We can reassure them by saying,

'Tape recording is an important part of counselling since it helps us to review what we have discussed and think about ways I can help you. It is also a method for my supervisors and peers to guide me. The information in the tape will not be shared with anyone else apart from my supervisor and peers. Your name or any information that can identify you will be deleted from the tape and, after this study,

The tape will be destroyed, if at any time during the session you want me to switch the recorder off, please let me know'

Note that if the patient still expresses discomfort about the session being taped, then we do not insist and switch off the tape recorder.

Ensuring good quality of recordings

It is important to ensure the sound quality of the recording is good. This can be done by:

- Keeping the recorder midway between us and the patient
- Locating the session in a place that is quiet and where we will be undisturbed
- Shutting the door/windows if there is too much noise around
- Requesting other people around (in the clinic or at the patient's home, depending upon where we are conducting the session) to speak softly so that the recorder does not pick up disturbance
- If there is a disturbance during the session (for example, someone enter the room or the telephone rings), we can pause the recording and restart it once the disturbance is over.

Guidelines for home visits

There are many practical barriers to patients attending counselling sessions in the clinic. To overcome such barriers, we generally suggest that, if patients are willing, we will conduct our sessions in a patient's home (or in some other place where they are happy for the session to take place, such as a temple or church, or someone else's home (a friend, neighbour or family member).

Pre-conditions for a home visit

Before conducting a home visit we must ensure the following:

- The patient has agreed that we can visit him/her at home
- Ensure we have detailed address and directions to the patient's home; ideally, this should be done at the end of the first session (which will usually be in the clinic) and serves as a reminder that the next session will be at home
- Arrange a day and time that is convenient for the patient when he/she is most likely to be at home and to be free from distractions/domestic duties
- If the patient has a phone, confirm that she/he is available at the time we plan to visit by calling him/her before visiting, especially if the patient requests this
- Discuss with the patient what she can tell neighbours who want to know why we are visiting. For example, the patient can say "This is a health worker from the PHC who has come to see me for a follow up". We must also discuss with the patient what we can tell people about why we are visiting (if we are asked) if we need to ask for directions to the patient's home.
- Ensure our personal safety–
 - Let our supervisor/health assistant in the clinic know our schedule and expected duration for the home visit. (I.e. inform/make a phone call to the supervisor/health assistant before and at the end of the home visit).
 - Leave a copy of specific directions to the home with our supervisor or appropriate clinic staff.
 - If possible take a colleague with us. (E.g. this could be the health assistant in the clinic; if available, a male health assistant should accompany a female counsellor). We can also contact the auxiliary nurse midwife (ANM) and coordinate the visit with her after discussing this with the patient.

- Always carry a mobile phone with us and ensure that the battery is adequately charged. Keep the telephone number of our supervisor and health assistant on speed dial so we can contact them urgently, if needed.
- Make the visit during daylight hours i.e. usually not before 8am or after 7pm.
- If we are in doubt of our safety, we must leave immediately. We can say: “I have forgotten important papers in the clinic.”

Other important points to remember during home visits

- On arrival at the patient’s home: always knock and announce our names, which we work at the PHC, and reason for the visit; wait to be invited into the home; be respectful.
- It may be difficult to ensure privacy during home visits. For example, there may be children, curious neighbours and other family members around. It is good practice to allow the patient to define his/her comforts of whom they want present during the session and we can discuss this with the patient in the beginning when planning the home visits. We can also discuss what the patient can tell neighbours/friends who drop by, such as *“This health visitor has come to see me from the PHC. Can you please come back after some time, say in an hour?”*
- Remember to make the best use of the home visit by concentrating on information and observations that may not be gathered as well in the clinic setting for example the patient’s interactions with family members. It is also a very good opportunity to involve family members/significant others in the counselling (this is described in greater detail in *Chapter 5*)
- Don’t forget to make the follow up appointment with the patient before leaving.

Listed below are some common challenges we may face when doing/planning home visits and suggestions of how we can deal with these.

Table 2: Common challenges faced during home visits and solutions to deal with them

Challenges	Solutions
When asking for directions, curious neighbours want to know reasons for the visit	Wear your ID card, introduce yourself as coming from the PHC, and do not reveal further details. If patients express concern about this, it is useful to ask patients in advance what you can tell neighbours about the reason for your visit
Patient may feel uncomfortable when visited by counsellor of the opposite gender – e.g. male counsellor visiting a female patient	Discuss with the supervisor and, if possible, get a same gender staff member to accompany you (e.g. a backup counsellor or health assistant)
Lack of privacy at the patient’s home with frequent interruptions from other family members	Ask the patient for a convenient time (e.g. when others are away) or request family members to give some time for the patient to talk. Slot in time at the end of the session for other family members to join and ask questions.
Patient is not prepared for the session e.g. busy or has visitors,	When fixing the session, specifically ask the patient for a convenient time. If patient has some work (such as housework) to finish, you can wait until this is done. Despite this, if he/she is not free, speak to the patient/family member and fix some other day for the session. Sometimes it is necessary to conduct sessions on Sundays – rearrange your week to factor this in.

Patient is under the influence of alcohol	Do not continue with the session. Tell the patient that you are unable to continue the session as he has too much to drink and that you will see him on another occasion.
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In situations where you feel threatened or where violence occurs:

<p>Dos</p> <ul style="list-style-type: none"> ✓ Move away from the person immediately ✓ Take a deep breath and try to be calm ✓ Be silent. If you think you have said something to annoy the person, you may say <i>“I am sorry if I said something to upset you”</i>. ✓ Wait for the person to calm down. Remain seated until this happens ✓ If this does not happen, leave the place, saying politely to either the person or the family member that you will contact them later over the telephone ✓ Try to get the help of the other family members if possible <p>Don’ts</p> <ul style="list-style-type: none"> × Do not shout/hit back or blame the person × Do not panic and run away from the house

Use of the telephone in counselling

The telephone is a useful tool for counselling, though its use is limited by the fact that not all our patients have access to a personal phone. If the patient does have a personal phone, it is important to get permission to call the patient on the phone in your first session. The phone can then be used in these specific ways:

Checking in with patients in between face to face sessions

In order to engage patients better in the counselling process, it is useful to make a brief, informal, call in between the home/clinic sessions to ask them how they are doing. If there is no response, we can also send a simple text message such as “Hello, this is XXX, your counsellor from XXX PHC. I hope you are doing well. If you would like to talk, please call me”. This is different from doing a full session over the phone or calling up to schedule an appointment.

This helps the patient feel supported by us and increases their engagement with the counselling.

Keeping contact with patients

If we are visiting patients at their home, we should give a brief telephone reminder either via a call or a text message before a scheduled home visit to make sure that they are expecting us. This can be sent a day or 2 before the scheduled appointment and we can place a reminder in our diary to make sure that we do this. If we are seeing the patient at the clinic instead of at home, again we should give a brief telephone reminder (text or call) one or two days before, to confirm the scheduled appointments. And if patients have missed their appointments, we can call to enquire what happened and reschedule the appointment

Conducting a counselling session

While face to face counselling at the patient’s home or in the clinic is the preferred method of counselling, sometimes there are barriers to this, for example care-giving responsibilities at home. At such times, we may need to conduct the counselling session over the telephone.

The advantages of telephone counselling are:

- **Saving cost and time:** Some patients may find it difficult to travel to the health centre due to various problems such as costs involved in travelling and not having time during the day due to work, or responsibilities at home
- **Greater flexibility:** The telephone provides flexible scheduling of appointments beyond working hours at mutually convenient times.
- **Greater privacy:** Telephone counselling may help to overcome the stigma and discomfort that some patients may feel in meeting us in the clinic or at their home.

However, there are also a number of limitations:

- Being physically present with the patient may help both of us feel more connected with one another; the telephone may contribute to "distance" in the counselling relationship.
- **Interruptions/disturbance:** Since we will be speaking to the patient while he/she is involved in his/her day-to-day life, calls may often be interrupted by other activities. This may make it difficult for the patient to maintain full focus on the counselling session.
- There may not be guaranteed privacy; for example, other family members may overhear the conversation
- Difficulty in carrying out the specific procedures used in the counselling, for e.g. demonstrating how the activity calendar is filled

If we are using the telephone for a session, we need to follow this procedure:

Before the call:

- **Obtain consent:** During face-to-face meetings, we must discuss with the patient his/her willingness to be contacted at home on the phone. If they are unwilling, then it is important to find out why and try to address their concerns. If, despite our efforts, the patient is still unwilling to accept telephone contact, no further attempt should be made to contact the patient on the telephone. The final decision should be documented in our notes.
- **Privacy and confidentiality:** This should be assured and maintained at all times. We need to ensure privacy at the patient's location and at ours. Make sure that we are alone in the room when we make the phone call to the patient. Request the patient to find a private space where they can talk freely. If the phone is shared with others, discuss with the patient how we should introduce ourselves in case someone else picks up the phone when we call.
- **Be prepared** with the various points that we need to cover during the call, as described below. Ensure that all written material we will refer to during the call (e.g. activity calendar and activity plan on pgs 15 and 23 from the [patient booklet](#)) has been given to the patient in advance and labelled for easy reference.

Initiating the call:

- **Introduce ourselves.** Remind the patient of the appointment we had made for the telephone counselling session. Give the introduction enough time – don't rush.
- **Ask the patient** if this is a convenient time to speak. If yes, proceed with the call. If no, arrange another time when we can call back.
- **Remember** this is most likely to be a new experience for the patient, so encourage participation and make an effort to reassure the patient.
- **If the patient** is not available when we call, ask when we can call back. Also ask the name of the person who answers the phone and his/her relationship to the patient (if possible). If the person who answers asks who we are, we can tell them what we have agreed with the patient we would say in such a case. If no one answers the phone, call back at three different times of the day on three days.

During the call:

- **Be focused**, sit up straight in our chair, and talk directly into the mouthpiece.
- **Be courteous**, pleasant and friendly. Remain respectful at all times.
- **Speak clearly** in a natural conversational manner. Our tone of voice, attentiveness and manner can make all the difference to the patient's comfort during the call.
- **Pay close attention** to what the patient is saying and how they are saying it. Listen for hesitation or pauses that may indicate uncertainty and may need us to explore further or verify.
- **Take it slowly**: give the patient time to talk without interruption and without having to hurry.
- **Allow** for interruptions

Concluding the call:

Provide homework as appropriate. Summarize all that has been discussed. Ask the patient if he/she has any questions or wants to add anything to the discussion. Make an appointment for the next call or home/clinic visit.

After the call:

Document the details of the call including the duration, content and our impressions of the patient's current state and future intervention plan.

Note: Specific information on how to deliver each phase of the psychological treatments is described in the [Healthy Activity Program](#) and [Counselling for Alcohol Problem](#) manuals.

SUMMARY

- Prepare ourselves for the counselling session by keeping a checklist of things we will need before the patient enters the room
- Greet the patient warmly and introduce ourselves
- Reassure the patient that confidentiality will be maintained
- Discuss the options of home sessions, clinic sessions and telephone sessions with the patient and identify the most convenient one
- Follow the guidelines that are recommended for home visits
- The telephone can be used to check in with patients between sessions and after the end of treatment, to remind patients of scheduled/missed appointments and to conduct counselling sessions

Chapter 4

Managing Crises

Learning Objectives

In this chapter, we will learn:

- How to manage suicide risk
- How to conduct a suicide risk assessment
 - When to refer suicidal patients
- How to apply effective skills and strategies for counselling a suicidal patient
 - How to manage personal crises
- What are the goals of crisis counseling?
 - How to assess a patient in a crisis
- What are the steps in crisis counseling?
 - How to help patients in bereavement
 - How to manage domestic violence

CONTENT

MANAGING SUICIDE RISK

CONDUCTING A SUICIDE RISK ASSESSMENT

Patients with mental health problems may, in the face of difficult life situations, be at risk of harming themselves - they may see death as the only way to escape from their problems. As a counsellor it is important to always ask if our patient has these thoughts so that we can provide help in finding solutions to his/her problems and thus reduce the risk of the patient acting out on these thoughts.

The assessment of suicidal risk is, therefore, an essential part of our work and must be integrated within all counseling sessions.

The most important points to remember are:

- It is our job to routinely ask whether the patient has any thoughts, urges, or acts of suicide or self-harm.
- Risk may change over time. Therefore, frequent review of suicidal risk is necessary in the same patient especially when their symptoms continue or worsen during the course of counselling.
- The patient may feel guilty or embarrassed about sharing information about suicidal ideas or plans. It is important to ask about suicide risk in a gentle, direct, and non-judgmental manner.
- Establishing an effective counselling relationship with the patient makes it easier to assess risk.

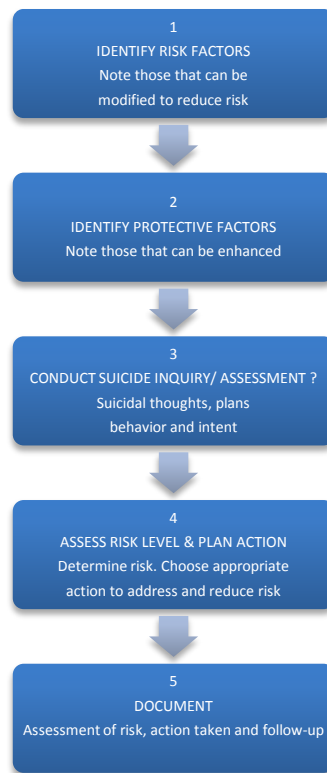
Suicide myths and facts

Table 3: Suicide myths and facts

Myth	Fact
People who think or plan to commit suicide keep their thoughts to themselves, and the suicide occurs without warning	Most often, people with suicidal thoughts will speak about these to someone they trust
Those who talk about suicide won't do it; they are just seeking attention	Communications about suicide or wishes to die must not be ignored
Talking openly about suicide may cause a suicidal person to end their life	By asking the patient about suicidal thoughts, we are providing him/her an opportunity to speak about thoughts that they may be uncomfortable to discuss for fear of being judged or criticised
We may be implanting suicidal ideas in the patient's mind by discussing it	

Suicide risk assessment is a five-step process

Figure 2: Five-step suicide risk assessment process



Identifying risk and protective factors

There are often factors in a patient’s life that either increase or decrease suicide risk. Risk factors are those that increase the risk of suicide attempts or death by suicide. Protective factors are those that are associated with a decreased risk of suicide. A listing of suicide risk and protective factors is useful when assessing suicide risk in each patient that we see. Some of these factors also may be modifiable and knowing these can provide a guide for which risk factors that might be reduced and which protective factors might be strengthened through counselling in order to reduce the risk of suicide. *Table 4*, below gives a list of such risk factors and protective factors.

Table 4: Suicide risk factors and protective factors

Risk Factors	Protective Factors
Personal Characteristics	

<ul style="list-style-type: none"> • Age: The risk of suicide is the greatest in young adults and in old age. • Gender: In the young, women are at higher risk; in middle and older age, men are at higher risk • Marital status: Single persons, persons who have recently lost their spouses or recently separated persons are at a greater risk of suicide. 	
<p>Health and Psychological Factors</p>	
<ul style="list-style-type: none"> • Presence of mental illness or chronic, serious physical illness • Chronic or severe pain • Feelings of hopelessness • Reduced self-worth, guilt and shame 	<p>The patient's ideas of the outcome of the suicidal act and the possible effects on children and family are frequently important factors that prevent suicide</p>
<p>Family Factors</p>	
<ul style="list-style-type: none"> • Family history of suicide or suicide attempts • Family history of violence • Parental divorce in childhood • History of physical abuse or trauma as a child 	
<p>Social Factors</p>	
<ul style="list-style-type: none"> • On-going and severe social stresses: Social stresses where a person feels trapped (large debts), ashamed or loses status (sudden loss of employment, failure in examinations) • Employment: Being unemployed or a recent loss of job is an important risk factor • Social isolation and lack of social support 	<p>Social support from and a sense of responsibility towards family, friends and other significant relationships like children who offer support.</p> <p>Religious and cultural beliefs that consider suicide as morally wrong can be a very important factor in preventing suicide.</p> <p>Community involvement and integration through employment and membership of groups can be powerful factors to reduce risks.</p> <p>Access to help like priests, counsellors and telephone hotlines where the person can discuss her problems in a confidential manner</p>
<p>Behavioural Factors</p>	

<ul style="list-style-type: none"> • Previous history of suicide attempt • Increased impulsive behaviour, i.e. doing things without thinking of their consequences • Increased anger • Recent violent behaviour • Self-harm • Loss of interest: i.e. when a person loses interest and withdraws from his/her usual social interactions with friends or family members or does not feel motivated to work any longer • Access to means of suicide like pesticides or large amounts of medicines • consuming alcohol and/or other substances • Final act behaviours such as giving possessions away, writing a suicide note 	<p>Positive coping methods used to handle difficult situations in the past</p>
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Conduct suicide assessment

We must first ask directly about **any suicidal risk**:

‘I can see that you are going through a very difficult period. In your situation, many people feel that carrying on with life is not worth it. Have you ever felt this way in the last few weeks?’

If we are using a questionnaire such as the [PHQ 9](#) (Refer HAP manual [Chapter 1](#)) the last item assesses the presence of suicide risk:

‘Do you have thoughts that you would be better off dead or of hurting yourself in some way?’

If ‘yes’ to any of these initial questions, we need to assess the degree of suicide risk. For this, we must ask for details:

1. Thoughts:
 - a. *What thoughts, specifically, have you been having?*
 - b. *How long have you been having these thoughts?*
 - c. *How intense have they been? How frequent? How long have they lasted?*
 - d. *Have these thoughts increased at all recently?*
2. Plan:
 - a. *Do you have a plan for how you would die or kill yourself?*
 - b. *What is it? Where would you carry this out? When would you carry it out?*
3. Means
 - a. *Do you have the means to carry out this plan?*
 - b. *To what means do you already have access?*
 - c. *What steps have you taken to gain access to means?*
 - d. *Do you have access to any weapons/poison?*
4. Acts
 - a. *Have you made any attempts? Have you taken any steps to carrying out this plan (e.g., counting pills, tying rope, etc.)?*
 - b. *What happened?*
5. What are the protective factors present in your life? (e.g., reasons to live vs. die)
 - a. *What are the things that help you to control or manage these thoughts?*

Assess suicide risk and plan action

After completing steps 1 to 3 above, we assess whether the risk of suicide is high, moderate or low. Assessing the risk level is essential as it will determine the next steps we should take.

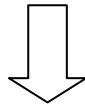
Table 5: Assessing suicide risk and planning action

Risk Level	Risk/Protective Factors	Suicidality	Action
Low	Few risk factors; adequate protective factors; mental illness with mild symptoms	Thoughts of death; no plans, intent or behaviour	Counselling to reduce symptoms and address problems; give emergency contact numbers
Moderate	Multiple risk factors; few protective factors; mental illness with mild to moderate symptoms	Suicidal ideas with plan but no intent or behaviour	As above; schedule early/frequent follow up
High	Acute, severe stressful event; very limited protective factors, mental illness with severe symptoms	Potentially life-threatening suicide attempt; persistent ideas with strong intent	Contact supervisor urgently; inform family/significant other; take actions described below

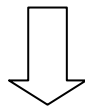
STEP-BY-STEP GUIDE TO MANAGE PATIENTS WITH HIGH SUICIDE RISK

Once a patient has been identified as having high suicide risk, the following action must be taken:

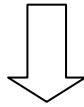
The counsellor informs the patient that in the interests of his/her safety, the supervisor will need to be contacted.



The counsellor calls the immediate supervisor, or if he/she cannot be contacted, the next supervisor on the list

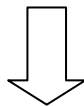


The counsellor provides details of the suicide risk assessment to the supervisor. This includes information about suicidality (i.e. suicidal thoughts/plans/intent/ access to means/behaviours/previous attempts) as well as information about risk (e.g. chronic physical illness) and protective factors (e.g. concern for children).



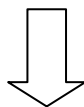
The counsellor then follows the instructions given by the supervisor. Among others, these might include:

- Involving a SO and/or other family member(s) and informing them about the high suicide risk. If the SO has accompanied the patient to the PHC, then the counsellor calls him/her into the room and provides the information. If the patient is alone, the counsellor asks the patient for contact details of a SO/family member and telephones the SO/family member, either asking them to come to the clinic (while the patient is still there) or, if this is not possible, provides information on the phone. The most important instructions for the SO are: maintaining appropriate supervision; knowing where the person is at all times and who they are with; and whom to contact in case of an emergency. The SO is informed about the importance of following up with the specialist as well as removing access to means of suicide, such as pesticides.
- Informing the PHC doctor of the high suicide risk and with his/her help, referring the patient urgently to a specialist. This may be the psychiatrist in the north Goa district (Asilo) hospital or to the Institute of Psychiatry and Human Behaviour (IPHB)
- Arrange for the supervisor to see the patient within 24 hours as far as possible



In addition, before the patient leaves, the counsellor ensures the following:

- Ensure the patient has immediate 24-hour access to suitable care. It is important to give the patient a list of contact numbers (the counsellor's and the supervisor's), that she/he can call if feeling suicidal
- Conduct an early follow-up assessment. This follow up must be with 24-48 hours and can be done over the telephone (if available) or preferably by a home visit. The counsellor must take the opportunity of speaking to an SO at the time of follow-up.



Ensure complete and timely documentation of the risk assessment and management. The points to be included in documentation include: whom did the counsellor contact; when did the various actions take place i.e. High risk identified, discussion with supervisor, family member informed, follow up session conducted etc.; and, what was the outcome i.e. supervisor advised counsellors should refer to psychiatrist, referral done etc

Remember, suicide risk is one of the situations where we are not obliged to maintain confidentiality. (*Chapter 3*)

Counselling a patient who is at risk of suicide

The counselling around the management of suicidal risk includes some general principles that must be followed before the patient leaves the session with us. These include:

Establishing a trusting relationship with the patient: This is the most important part in counselling patients at risk of suicide and makes the patient feel that his/her problems are being understood in an empathic manner and that we are not judgmental about his/her suicidal thoughts. To achieve this, we must be always using our counselling skills of verbal and non-verbal communication in an appropriate manner.

Encouraging the patient to talk about his/her problems: It is important to allow the patient to talk freely about his/her concerns and distress with us. Suicidal ideas may cause a lot of distress to patients because of the associated guilt and the idea of it being a sign of ‘weaknesses. Frequently, patients will become emotional and tearful during this time and we need to be supportive without encouraging the idea of suicide (i.e. we may validate the patient’s distress but agree with the act of suicide as a solution).

Restore hope: Suicidal thoughts are commonly associated with feelings of hopelessness. It is important to assess such thoughts and encourage the view that problems can be solved and that coping is possible. We may identify, explore and praise the patient’s ability to cope with past crises or difficulties. If the patient is talking about feeling helpless and hopeless, we may ask him/her to recall another time when they may have felt like this and were able to cope. This gives the patient some confidence and hope. It may be helpful to use a structured problem-solving method (described in [HAP](#) and [CAP](#) manuals) and help the patient to resolve any immediate conflicts with others or problems that are contributing to the suicide risk.

Focus on protective factors: We can discuss with the patient the reasons for not acting on their suicidal thoughts. E.g. dependent children, religious beliefs, positive relationships with others. In order to gather this information, we can ask questions such as:

“Can you think of reasons for why you may not consider taking this step?” Or, “what impact will this have on others around you?”

Activate family/social supports: It is important to involve family members in caring for the patient and in problem solving. Encourage a supportive network consisting of friends, neighbours, community support groups (such as Alcoholics Anonymous)

Remove all means of committing suicide: E.g. medication, pesticides, and rope. We can involve an SO to supervise this e.g. locking away medication or pesticides in a closed cabinet.

Ensure the patient has immediate 24-hour access to suitable care: It is important to give the patient a list of contact numbers, including our own, that she/he can call if suicidal risk increases and to ensure that specific plans are in place if one or more of the contacts are unavailable.

Make a contract about not to harm one's self: We can make a “contract” with the patient in whom he or she promises not to attempt suicide within an arranged (short) period of time. It is important that the patient actually says the words – that s/he promises not to harm her/himself, for e.g.: Before ending the counselling session we can say:

‘Before we end this session it will be really helpful if you can reassure me that you will contact me / talk to your relative immediately if you start getting these thoughts again and you will not take any action before we discuss it. Is that acceptable to you? (And if they say ‘yes’ then: So will you reassure me? Will you promise me that you will not harm yourself or take any action like that until we have discussed things?)’

Always conduct an early follow-up assessment: We must give the patient an appointment to see us that is scheduled earlier than usual. In addition, we can make follow-up telephone assessments (or home visits, if necessary) at frequent intervals, even daily, if required.

Remember: We do not let the patient leave the interview room until we are satisfied that we have taken the necessary precautions around ensuring safety.

Documentation

Adequate documentation of the risk assessment and counselling plan on an on-going basis is very important. For example, documenting that we consulted appropriately with the Supervisor, and/or met with family members and discussed this issue with them is important.

It is also important for us to fully discuss the suicide risk of our patients during our supervision session. (*Chapter 6*)

MANAGING PERSONAL CRISES

It may happen that a patient you are counselling may be exposed to a potentially stressful extreme event. Such personal crises can be precipitated due to various reasons. Below is a list of some events that can precipitate personal crises:

- Death of a loved one
- Failure in examination
- Domestic violence
- Sudden financial loss
- Loss of job

Patients facing personal crises may start feeling overwhelmed due to the severity of the problems in life. Important reactions to the personal crisis include:

- Feeling of loss of control
- Feeling lonely and unsupported
- Feeling less hopeful
- Feeling suicidal

Patients facing personal crises may experience the following symptoms

- Restlessness
- Feeling sad
- Raised heart beats
- Shaking hands
- Reduced sleep

- Reduced desire for food
- Anger
- Suicidal thoughts

Often patients start experiencing these symptoms immediately after the crisis has occurred. At such times, it is important to focus on helping the patient to achieve the following goals:

- To reduce the distress
- To gain more control over the stressful situation
- To restore hope and optimism
- To restore, over time, his/her pre-crisis level of functioning.

These goals can be achieved through the following steps.

Steps

- 1) Providing emotional support to the patient so he/she can express feeling about the crisis
Often patients facing personal crisis are overwhelmed by their emotions and it is important for us to offer them a calm and unhurried hearing. All the basic counselling relationship skills described in Section 2 should be used in this process. Use of warmth, empathy, genuineness and acceptance are of specific importance in this situation. Patients often feel unsupported and lonely. Providing them emotional support helps they cope with such feelings. We can help patients to express his/her feelings by using the techniques of asking open ended questions, reflecting, and providing summaries.
- 2) Assessment: the following areas are recommended for assessment (if a patient has not elaborated on them in the earlier phase)
- 3) Patient has not elaborated on them in the earlier phase
 - Understanding the nature of the event/experience and making a list of the stressors the patient was/is exposed to.
 - Understanding the time frame (when the patient's distress began and how long it has continued).
 - Assessing the patient's level of functioning prior to the event/experience.
 - Assessing the patient's current functioning, i.e. following the distressing event/experience.
 - Assessing suicide risk (refer section above)
 - Sometimes patients do not feel comfortable in describing details of the stressful situation. In such situations, it is important not to force the patient to talk about the event in detail as this may increase distress.
- 4) Improving skills to face the crises: The next step is to work with the patient to improve his/her skills to face the crisis situation. The following techniques can be used:
 - Helping the patient to normalise distressing emotional experiences: E.g. For a student who is experiencing a personal crisis due to failure in an examination, we can say:
'Failures are really difficult to deal with, especially when you worked so hard for these exams. Your feelings of anger and frustration are very understandable in this situation'
 - Helping patients to focusing on their strengths from the past: e.g. for a person who has successfully faced similar situations in past, counsellor can say:
'As you told me earlier, you managed to overcome the problems caused by your sudden loss of job in a very effective manner...'

- Providing hope and reassurance: E.g. for a person who has a sudden financial loss, we can say:

I know it is really tough to face such a huge financial loss but I am sure if we work together we will find some solution to this problem.

If suicide risk is present, manage this as described above

In addition to above mentioned techniques, we can encourage the following behaviours:

- Physical exercise
- Healthy diet
- Regular sleep patterns
- Social interactions
- Productive participation in tasks and at work.

And, discourage the use of alcohol and drugs, social isolation and excessive work.

5) Involvement of significant other (SO)

Helping the patient to communicate feelings to and interact with an SO is a useful method of coping with personal crises. Involvement of an SO is focused on increasing the ability of the SO to support the patient following an extreme event or challenging life experience in the following ways:

- Encouraging the family to unite together; this protects the patient against the stress associated with an extreme event or distressing experience by mobilizing the support of family members.
- Encouraging the SO to reassure the patient, acknowledging to the patient that they will provide safety and comfort.
- Advising the SO to listen to the patient's feelings. This includes giving the patient time to express him/herself without minimizing or ignoring his/her feelings. The SO can help by encouraging the patient to express emotions s/he may find difficult, such as anger or grief.

(Chapter 5 describes involvement of so in counselling)

It is also important for us to fully discuss these personal crisis episodes of our patients during our supervision session. (Chapter 6)

Sometimes, despite our best efforts, the discomfort generated though the personal crisis continues. It is important to refer such patients to the supervisor for further management.

Case example

Krishna is a 35-year-old man. He was working in a small scale industry as a clerk. He lives with his two children and wife and is the only earning member of the family. Five days ago his employer called him to his office and told him that due to the company's financial losses, he cannot pay Krishna's salary and Krishna should look for another job next month. Krishna is very upset and asks to see the counsellor urgently.

Who said	What did they say?	Comment
Krishna	Sorry for asking for an urgent appointment. But I am terribly upset for last three days since my boss told me that from next month I should search for another job. I had to meet you.	
Counsellor	No problem Krishna, I have already told you that you can contact me for any emergency and I can very well understand how disturbed you must be with this news. Your	Acceptance and empathy

	job was so important for you.	
Krishna	I just could not sleep for last two nights due to the thoughts of what will happen to my family if I lose this job	
Counsellor	You are very anxious of how this job loss will affect your ability to take care of your family.	Reflection
Krishna	Yes, I am terribly upset	
Counsellor	Hmm Hmm	Minimal encourager
Krishna	What will happen to my family if I lose my job? Both my children are young and I am the only earning family member	
Counsellor	This is really tough situation for you	Reflection and empathy
Krishna	I am so worried.... I just cannot stop thinking about this	
Counsellor	Hmm Hmm	Minimal encourager
Krishna	How do I support my family, now? Can you tell me what to do?	
Counsellor	As you know, I am here to help you. I am confident if we join hands, we will find a way to deal with this problem.	Hope and reassurance with collaboration
Counsellor	Apart from feeling restless, reduced sleep and excessive thinking and feeling like crying are there any other things you are experiencing	Open question
Krishna	No that's all	
Counsellor	As you said you are thinking a lot about this. Have you thought of any options on how to tackle this situation?	Alternative ways of handling situation
Krishna	There are some job openings in our field but I am not sure whether I will get those jobs	
Counsellor	Good that you have already started thinking about the options. Are they better than this one?	Affirmation
Krishna	Not all but for some of those jobs they are offering a better salary than this	
Counsellor	That's reassuring...maybe you will be able to think of other options, too?	Encourager
Krishna	Maybe but I am so disturbed at the moment that I can't think of any alternative.	
Counsellor	That's very normal Krishna. Most people in your position would feel the same way.	Normalisation of experience
Krishna	(Nods)	
Counsellor	But as all of us know that it is a temporary phase and once you feel a bit better your mind will start thinking clearly	Reassurance and hope
Krishna	Yes, I know...	
Counsellor	That's good. One more thing Krishna, have you shared this news with your wife	Involving SO
Krishna	Not really. I am afraid she will also become tense.	
Counsellor	I can understand your concern Krishna but sometimes it is useful to share your problems with your loved ones so they can share some of your burden and also help think of	Involving SO

	possible solutions.	
Krishna	Yes that's also true. I will try and talk to her and see if she can suggest some thing	
Counsellor	That's great. Have you realised in this short time, you yourself have started generating some solutions to this problem.	Affirmation

HELPING PATIENTS IN BEREAVEMENT

When a patient you are counselling has experienced a recent loss of a loved one, it is important to follow certain guidelines so that we help the patient feel supported at this difficult time in his/her life. The immediate goals of counselling the patient are:

- To express empathy and provide the patient with space to express his/her grief
- To help the patient access available means of support

What you can't do in the session

Express your condolences at the loss. If the patient does not wish to speak, sitting with him/her in silence for a while is also helpful. If the patient is willing to speak, we can:

- Encourage him/her to talk and express sadness about the loss.
- Encourage the patient to describe the events just prior to, during, and after the death, for example, talk about the death scene.
- Encourage the patient to discuss his/her relationship with the deceased e.g. what she/he misses most about the person, etc.
- Explore sources of support e.g. other family/friends that the patient can draw on to help cope with the loss.

If the patient has immediate concerns such as uncertainty about care of the children or financial worries, allow him/her to speak about these and provide reassurance that we will help in finding ways to deal with these problems.

MANAGING DOMESTIC VIOLENCE

In this section we will learn how to:

- Assess domestic violence
- Respond when a patient reports that he/she is a victim of domestic violence.
- Respond when a patient reports he/she has perpetrated domestic violence

Domestic violence is the use of abusive behaviours by one partner against another in an intimate relationship. This could take the form of actual or threats of physical aggression or assault (hitting, kicking, shoving, slapping, throwing objects), sexual abuse (abusive name calling, refusal to use contraception, deliberately causing unwanted physical pain during sex, sex without consent and to cause pain or shame) or emotional abuse (rejecting, ignoring, isolating, shaming, threatening, neglecting).

From time to time we will encounter patients who are victims of violence or who are themselves violent towards close members of their families, most often their wives (but also, sometimes, towards children or parents and sometimes towards their husband). In such situations, we need to remember that it is our duty to intervene and we could make a difference to the situation by intervening. Furthermore, our efforts to intervene could also help to influence the violent person's behaviour and ensure safety of the victim.

How do we ask about domestic violence?

Asking someone who is a victim of domestic violence to speak about the violence is a very sensitive issue. Asking about how the patient's relationship is going might lead to him/her telling us

about domestic violence. We could start off with a simple question such as: *How are things at home?*” or *“What is your relationship with your husband/wife like?* If the patient says that things are not good, then ask further details, such as: *Can you tell more?* It is then important to ask more directly for domestic violence, you can do this by asking for details of conflict and then asking what happens during a quarrel. Ask specifically if the patient or the spouse is violent during such quarrels/arguments.

Remember, if the patient or relative strongly denies that violence occurs then we should be careful not to push too hard as it could lead to an increase in domestic violence.

When asking a man who drinks if he is/has been violent, we may ask,

‘How is the drinking affecting how you are with your family? Or how do you think alcohol affects your behaviour?’ This might prompt him to tell us about domestic violence.

Sometimes it is not the patient who tells us about his domestic violence but it is his/her spouse who does this. The script below provides guidance on how to handle such a conversation.

Script 1

Wife (to husband)	<i>You are telling him about your drinking but you are not telling him that you hit me when you get drunk!</i>
Patient	<i>Silence</i>
Counsellor	<i>You are not saying anything Mr D’Silva. Would you like to respond to what your wife has said?</i>
Patient	<i>What is there to say! I do not like to talk about such private things here.</i>
Counsellor	<i>I do understand that, Mr D’Silva. But this does sound like one of the effects of drinking, and we are trying to get a list here of some of these effects, so we can get clear what it is that you want to change. So tell me, Mr D’Silva, is this something that you agree happens, and that you’d like to change?</i>
Patient	<i>Yes, it does happen. And yes, I would like to not get so angry. But she makes me angry by being so argumentative!</i>
Counsellor	<i>OK, I can hear that: you feel that she gets argumentative when you come home drunk, you get very angry, and sometimes you then hit her – is that right?</i>
Patient (quietly)	<i>Yes</i>
Counsellor	<i>And is that how you see it, Mrs D’Silva?</i>
Wife	<i>No, I do not get argumentative – I am angry too, as he comes home, drunk, he has spent lots of our money, and I am worried that we will not have enough to pay the bills – so of course I get angry and scold him. It is him that is wrong for hitting me! Instead he should not go drinking and spending all of our money!</i>
Counsellor	<i>OK, Mr and Mrs D’Silva – I can hear clearly what both of you are saying, and I can see that each of you is seeing things from your point of view – and from that point of view, you feel justified in saying and doing the things that you do. Can I please make a suggestion here? (They nod) This is a problem</i>

	<i>that we can sort out! I am sure that I can help you to stop having these arguments which turn into violence. But a problem like this can also be difficult, so I'd like us to start on something that is a bit easier to tackle – if we tackle easier problems to start with, we get success faster, and then we can all feel confident that we can make the changes we need to. Is that OK – which we work on another area first and come back to this in a while? And if we manage to help you, Mr D'Silva, to stop getting drunk and therefore stop coming home drunk, then your wife will not feel the need to scold you and then you won't get so angry – so maybe that will help, even before we start to work on that problem!</i>
Mr and Mrs D'Silva	<i>OK – we are happy to come back to this later</i>
Counsellor	<i>But one final thing before we move to another area – sometimes when things like this are said in counselling (and Mr D'Silva – you are not the first person that I have seen where someone, when they are drunk, becomes violent to his wife), the husband brings it up again with their wife after the session and that also leads to anger and more violence. So can I ask you both to promise me that you will not bring up at home the fact that this issue has been raised here?</i>

How do we help a patient who is a victim of domestic violence?

Step 1:

It is important to make the patient feel as comfortable as possible by using active listening skills and creating an environment in which she/he can share confidential and sensitive information

We can say:

'I am glad that you told me about this. It must have been difficult to disclose such a sensitive issue to someone you are meeting for the first time (or have met only a few times)

Step 2:

If the patient arrives at the PHC with visible injuries, we should immediately refer him/her to the doctor for medical treatment and documentation of the injuries. The patient is also to be informed of his/her right to file an incident report at the nearest police station.

Step 3:

Examine a range of appropriate options and give the patient the freedom to choose what he/she feels is best. Guide him/her in the problem-solving and decision-making process. Many times, the patient may be so affected by the violence he/she is facing that he/she will actually believe there are no options available to him/her. Explore alternatives and present those that are most realistic to him/her situation. These may be:

- *Identifying people* who know and care about the patient and who can help;
- The use of *coping mechanisms* – actions, behaviours that are protective e.g. identifying triggers for the violence and avoiding them, keeping a telephone number handy for whom the patient can call for help
- Talking calmly to the person who is violent telling them they are hurting you
- Avoiding/moving away from the person who is threatening violence
- *Resources* to get through the crisis e.g. referral to women's groups, legal action, police reporting
- *Negotiation* with the person who is violent (see below)

Negotiation: The process of negotiation involves discussion between the patient, the person who is violent, and the family members involved. The primary goal of the negotiation process is to enable the patient to communicate his/her problem to the perpetrator, enable the perpetrator to respond to the patient, and for both to come to a satisfactory solution without taking any legal action. If a patient chooses negotiation as his/her plan of action, we should contact our supervisor who will help us plan how this can be done.

Step 4:

Make a plan of action along with the patient so that he/she feels a sense of ownership of the plan. Whether the plan involves negotiation, police reporting, legal assistance, or referral to other services, it is important for us to explain the details of the process as clearly as possible. In order to help the patient choose from one of the options available (for example, negotiation or legal help), we can follow the steps in problem solving (see **HAP manual Chapter 4**) and discuss the advantages/disadvantages of each option. By the end of the meeting, we verbally summarize the plan with the patient and agree to it.

How do we help the patient to stop being violent?

Step 1:

We must first acknowledge that his disclosure is an important first step towards finding a way out of the difficult situation. We could say the following

Counsellor:

‘I am glad that you told me about this. It must have been difficult to disclose such a sensitive issue to someone you are meeting for the first time (or have met only a few times)

Step 2:

Stress that his behaviour is a choice and he can choose to stop. One way of putting it is as follows

Counsellor:

‘Just as we have learnt (or are going to learn) that drinking is a choice that you have made from the various options open to you, being violent is also a choice that you have made from the many different options open to you and you can choose differently. Also, just because you’ve been violent in the past it doesn’t mean you have to be violent again.

Step 3:

Help the patient to recognise the warning signs. The patient should learn to be aware of when things are getting out of control and he is getting into a situation where he may be violent. The more he is aware of such warning signs, the more he will be able to stop himself from actually becoming violent. Based on what has happened on past occasions when the patient has become violent, we can work with the patient to recognise warning signs in some or all of the following areas:

- **Typical situations:** These could include arguments over money, criticism over patient’s drinking etc.
- **Physical warning signs:** These include tension in the body, heat, changes in breathing and heart rate, finger pointing, closing of fist, pacing up and down the room, rising of voice or shouting, going quiet etc.
- **Emotional warning signs:** These include feeling resentful, angry, trapped, confused, persecuted, challenged, guilty, embarrassed, upset and hurt.
- **Mental warning signs:** These include negative things about the wife/family member, for e.g. *‘She is doing this deliberately to irritate me’, ‘she is so stupid’, ‘she never gets anything right’, ‘she never listens to me’, etc.*

Step 4:

Taking ‘time out’. Once the patient recognises some or all of the warning signs, the next time he gets into a situation where he recognises the warning signs he can choose to take a ‘Time out’ (i.e. walk away from that situation). If he walks away and is not near his partner/children then he can’t

hurt her/them physically. This also gives him breathing space to think about his behaviour, away from the situation. Here is what we could say

Counsellor:

‘As soon as you recognise any of the warning signs we identified, don’t wait until things get worse. Tell your wife that you need a break – and leave. Go to a different room or away from the house till you calm down.

Step 5:

What to do during time out. He should use this time to calm down. Some things that he could do are:

- Don’t drink more alcohol as it will make things worse.
- Do something physical, such as going for a walk, which may reduce the physical build-up of tension.
- Do something else such as pray, meditate, or talk to a supportive friend.
- Do something you know you enjoy, such as listen to music.

Once he has calmed down he must return home. He could then discuss the situation with his wife/family member in a non-abusive and non-blaming way. Sometimes it helps to talk about this after a good night’s sleep after he has sobered up.

If domestic violence continues and if we feel unable to tackle the complexity of the situation, we must discuss the case with our supervisor.

- These are also steps we can follow to help patients who may not be violent but who have trouble controlling their anger.

SUMMARY

- It is essential to assess a patient for presence of suicide risk
- If risk is present, it is important to ascertain the degree of risk since this will guide us about the appropriate course of action
- If we judge any patient to have high suicide risk, we must discuss this with our supervisor without delay
- We must take urgent action for any patient at high risk of suicide
- Crises counselling may be needed for patients facing acute personal crises
- Respond sensitively to patients who are in bereavement
- People who experience domestic violence or who are themselves violent need help to deal with this. Speak about the violence in a non-judgmental manner and guide the patient to the help that he/she feels is most appropriate.

Chapter 5

Involving Significant Others (SO) in Counselling

Learning Objectives

In this chapter, we will learn:

- Why do we need to involve an SO in counseling?
- What are the situations in which we will need to involve an SO in counseling?
 - How to involve an SO in counseling
- What are the necessary precautions while involving an SO in counseling?

CONTENT

A Significant Other (SO) can be any person in the patient's life who plays an important part in the patient's emotional well-being and is ready to participate in the counselling treatment to help the patient overcome his/her problems. Most often, an SO is a close family member but sometimes an SO can be a friend or a well-wisher, such as a caring neighbour.

WHY DO WE NEED TO INVOLVE THE SO IN COUNSELLING?

Family and friends (i.e. significant others) form an important part of an individual's life in our culture. Often, mental health problems faced by a patient are related to their family life. Family relationships may have a two-way effect on the mental health of the patient.

- Family relationships can be a cause of a mental health problem: e.g. domestic violence leading to depression in women.
- The mental health problem can cause family relationship problems e.g. harmful drinking of alcohol by the patient can affect his relationship with his wife and children.

Advantages of involving the so in counselling

- Inputs from the SO helps us better understand the problem e.g. details of the mental health problem from the family member can be helpful to assess the effect of the problem on the patient's life
- The SO can play an important role in helping the patient in deciding the treatment plan, for e.g. deciding about the goal of the treatment
- The SO can play an important role in helping the patient in following the treatment plan, for e.g. helping the patient in completing homework tasks and attending counselling sessions by providing timely reminders
- Feedback provided by the SO can often be very meaningful to the patient and can help the patient become motivated to change and gives hope for recovery.

Goals of involvement of the so in counselling

- Obtain inputs from the SO to better understand the patient's problem
- Raise the SO's awareness about the extent and severity of the problem
- Strengthen the SO's commitment to help the patient in dealing with and ultimately recovering from the mental health problem

How to involve the so in counselling

If the patient has come for the session alone, this is how we can introduce the involvement of the SO to the patient and get their consent for the SO's participation in counselling:

'It is useful to have someone close to you join us for these counselling sessions. We will explain the counselling treatment to this person. This will help them understand what you are dealing with and we can think about how they may be able to help you get better.'

Who do you think this person can be? Will you bring them with you at the next session?'

We can then give the patient the Hand-out for Significant Others for [alcohol problems](#) and [depression](#) which is described in the **HAP and CAP** manuals.

If we are conducting a counselling session in presence of the SO, then these steps can be followed to increase the participation of the SO in the counselling:

Steps

Explaining to the SO his/her role in counselling:

The following example helps us understand how we can do this.

Counsellor:

‘Thank you Mr & Mrs Pawar for coming for the counselling session. Mr Pawar, I’m really pleased that you are accompanying your wife for the session. I believe that family members can play very important part in helping their loved ones to cope with the problems of daily life. As we start the counselling session, first I am going to talk to your wife so that I can understand her problem from her point of view, but it will be really helpful if you can also participate in the conversation, if you feel there is something important about her problem that you can share. After I have listened to what you both have to say, I will explain to you both how I understand the problem – and I’d like to ask you, Mr Pawar, to pay specific attention when I do this, so you will also be able to understand it in a better way. Something else that I’d like to discuss during this counselling session is your role in this treatment. Does this plan sound acceptable to both of you?’

Exploring details of the problem from the SO’s point of view

Once we have started to talk to the patient and got his/her viewpoint, we can ask the SO his/her experience of dealing with the problem

- What have you noticed about the patient’s problem?
- What are the ways in which you have tried to help the patient overcome the problem?
- Are there any effects of this problem on you or other family members?
- Often, information presented by the SO in response to the above questions helps us improve our understanding of the problem that patient is facing.

Addressing the SO’s expectations from counselling

- If the patient is attending the counselling session with the SO then it is important for the counsellor to know the SO’s expectations from the treatment as well
- If the patient agrees, the SO can be involved in the process of goal setting by expressing their own views and by contributing to generating options. The aim of this process should be to agree on the goals which are mutually satisfactory.
- If we can agree on the mutually acceptable goals then this can reinforce the patient’s commitment and improve the relationship of patient and SO and the positive role of the SO in enhancing recovery.

How we can involve the SO in different phases of the actual counselling is described in the HAP and CAP manuals

Challenges in involving SO in counselling:

- Presence of an SO may sometimes interfere in the counselling sessions e.g. spouse being over-critical about the drinking behaviour of husband; or a spouse being very dominant or opinionated about what the patient should do. The section below on handling disruptive behaviour of an SO can help us to learn skills to handle such situations.
- Certain interpersonal problems can be difficult for counsellors to address due to the nature of the problem. For example, marital conflict in which one partner is involved in another relationship and unsure about his/her commitment to the marriage. These may require a high level of competency in counselling skills that is generally achieved through extended periods of training and supervision. It is useful to refer such patients to our supervisor.

- Involving the SO in treatment can sometimes become an obstacle in achieving the desired change in the patient’s life and may even lead to a worsening of the situation. It is important for us to identify these potential situations and deal with them.

Table 6: Challenges of involving an SO and the possible solutions

Challenges	Possible solutions
Comments made by SO appear to worsen the problems in an already strained relationship	Limit SO involvement in the counselling process to specific areas such as providing information about nature of illness rather than in decision making
Comments by SO suggest hostile or indifferent attitude towards patient	Explain to the SO how their input is being unhelpful, and suggest ways that they could give the same feedback in a helpful way.
SO is unable to make the changes in his or her behaviour that may be helpful in changing the patients problems	Focus the session on the patient and his/her problem rather than on the SO

Case example

Handling challenging situations

Hostile reaction by the SO

Husband of patient: She complains of body ache all the time and there is nothing really wrong with her health. She is just being lazy. She just doesn’t want to do the housework. Instead she quarrels with me all the time.

Counsellor:

‘I really appreciate your coming to speak to me about your wife’s health and its impact on your family life. Her body ache and her inability to do work are a result of the stress she is experiencing. Together we can think of ways to help her cope so that she is able to do all that is needed. Your support is very important to help her feel better.’

Non-agreement between patient and the SO about the goals of treatment

Wife of patient:

‘I don’t believe in this control of drinking to one peg per day thing. He should stop drinking alcohol completely’

Counsellor:

‘I appreciate your concern about your husband’s drinking and I can see that both of you have different expectations from treatment. What do you think about first starting with the patient’s choice but at the same time making note of your expectations from the treatment and reviewing them later based on the results that we achieve?’

SO disagrees with the need for counselling

Husband of patient:

‘I think her coming to you for counselling is a waste of time. She should just stop worrying and focus on the children’s needs.’

Counsellor:

‘I can see you are concerned about the children and want her to look after them as she was doing earlier. Let me explain to you how this counselling will help her do just that....’

Script 1: Involvement of the SO

Mr Patil has come to visit you for his problem of drinking. He is also accompanied by his wife. You have already done the detailed assessment of the patient's problems and now you also want to involve Mrs Patil in the treatment.

Who said	What did they say?	Comment
Counsellor	Mr Patil, will it be ok if we ask your wife about her observations about your drinking?	Counsellor seek patient's agreement for involving SO
Patient	Sure, Why not	
Counsellor	Mrs Patil , Can you please share with us your observations about your husband's drinking	Counsellor requesting SO to share information about patient's drinking
SO	I agree with most of the things that he said just now. His drinking has started increasing since last 6-7 months and we are really worried about that. This has started to affect his own health and our family life.	
Counsellor	Can you please tell me what kind of impact it is having on your family	Open question
SO	As he spends two / three evenings per week with his friends in drinking, his time with the family is reduced significantly over last six months	
Counsellor	What do you think about that Mr Patil?	Counsellor involves patient in the conversation
Patient	Yes, I agree. I realise that of late my time with family is reduced significantly	
Counsellor	(looking at Mr Patil) Can you think of any solution to this problem?	Encourages patient to generate solutions
Patient	I need to start taking more responsibility in the family. Maybe I should start helping my children with their homework. If I do this then I may not think of going out with a friend and will not end up drinking	
Counsellor	That's great! (Counsellor turns to Mrs Patil) what do you think about that?	Provides affirmation
SO	That is really good suggestion so he will spend more time with the kids and I can also have some breathing space for myself	
Counsellor	(Looking at SO) That's great! Is there any other information about his drinking that you want to share with me?	
SO	One more thing that is bothering me about his drinking is that on Sunday he starts drinking from early afternoon.	
Counsellor	(Looking at patient) What do you think about this Mr Patil?	
Patient	I have already told you that I am going to stop drinking completely	
Counsellor	I really appreciate your determination Mr Patil. Is there	Providing affirmation.

	any way Mrs Patil can help you in achieving this?	Counsellor asks patient how SO can help patient in achieving goals
Patient	One thing I have observed over last few months that if I have a heavy breakfast on Sunday morning then I generally do not think of drinking in the afternoon. If she makes it sure that I have a heavy breakfast on Sunday morning then it will be really helpful.	
Counsellor	Will that be possible for you Mrs Patil?	
SO	Yes By all means.	
Counsellor	That's great	

Script 2: Involvement of SO

Mrs Pawar has come to visit you for her problems with depression. She is also accompanied by her husband. You have already done the detailed assessment of the patient's problems and now you also want to involve Mr Pawar in the treatment.

Who said	What did they say?	Comment
Counsellor	Mrs Pawar, will it be ok if we ask your husband about his observations about how you have been feeling?	Counsellor seek patient's agreement for involving SO
Patient	Yes, that is ok, but I know he is frustrated with me.	
Counsellor	Mr Pawar, Can you please share with us your observations about your how your wife has been doing?	Counsellor requesting SO to share information about patient
SO	I agree with most of the things that he said just now. She started to stay in bed a lot over the past few months. I am frustrated because I don't know what to do with her. Our children are not being well cared for. This is not like her.	
Counsellor	Can you please tell me what your concerns are or what kind of impact it is having on your children?	Open question
SO	She seems so unhappy all the time. I tell her to get going back to the temple but she just turns away. And our children are cooking their own breakfasts now. I need to go to work so I cannot be there to force her to get up. It is a terrible situation.	
Counsellor	What do you think about what your husband is saying, Mrs Pawar?	Counsellor involves patient in the conversation
Patient	Yes, I agree. I realise these problems but I cannot change it. I am tired all the time and I do not have the energy to take care of the children in the morning. I just lie in bed thinking over and over of what a mess our home has become, what a bad wife and mother I have become.	
Counsellor	I am sorry that it has become so stressful. You are describing the experiences that many people have when stress is high. The good news is that we have some	Provide hope and reassurance; suggests engaging

	ways to improve this situation and help you feel better. I feel confident that we can work together to find some good solutions for you. I wonder if you would be agreeable to the idea of you and Mr Pawar and I meeting together to discuss these problems and explore some solutions.	SO in treatment
Patient	Yes, I would like that. I don't know what to do.	
Counsellor	That's great! (Counsellor turns to Mrs Patil) what do you think about that?	Provides affirmation
SO	Yes, I am willing to help if I can. I need to be working so I cannot spend all my day coming to appointments but if you think it can help, I can bring her here to meet with you.	
Counsellor	(Looking at SO) That's great! I want to share with you that your input is very important to me; it helps me to understand the situation at home and the experiences that Mrs Pawar is having. The more that I understand, the more able I will be to help you both. Also, I think that your support of her treatment here is very valuable. There may be ideas we can generate together that give you specific things to do at home to help her feel better and help your family get back to the ways you want.	
SO	That would be good. I just don't know what to do anymore.	
Counsellor	(Looking at patient) What do you think about this Mrs Pawar?	
Patient	Yes, yes. That is good. Last week when he drove my sister to our house to visit for the day it was very helpful and I did manage to get the cooking done.	
SO	I didn't know that you did the cooking. I thought your sister did it.	
SO	No, no, I did it while she took the children out.	
Counsellor	This is a great discussion, and these are exactly the kinds of things I feel confident we can discover together. Perhaps we can discuss more regular ways to have your sister help out for a while? I really appreciate both of you being willing to work on this. I think it is a great sign of hope for things improving.	Providing affirmation. Orienting to the role of the SO in achieving goals.

SUMMARY

- An SO in the patient's life may contribute to the mental health problems that the patient faces. They, in turn, may also be negatively affected by these problems.
- There are several advantages in involving the SO in counselling both in understanding the patient's problems better and in identifying and trying out solutions.
- You must be aware of the steps necessary in SO involvement: explaining their role in the treatment, developing an effective counselling relationship with the SO, getting details of the patient's problems and addressing the SO's expectations from treatment.
- SO involvement is challenging and addressing these challenges is important to gain maximum benefit from their involvement

Chapter 6

Becoming A More Effective Counsellor

Learning Objectives

In this chapter, we will learn:

- How to keep contact with patients
 - How to maintain standards
 - What is supervision?
- When to refer and to whom
- How to maintain boundaries

CONTENT

WHAT IS SUPERVISION?

By supervision, we mean guidance and support that is provided in a helpful and constructive way. There are two key characteristics of supervision:

It is formal. It is not a casual chat when we feel like it or when there happens to be someone around. It is a scheduled session and it is our responsibility to ensure we attend the supervision on time and are well prepared.

It is regular. If we see a number of patients on a regular basis, it is important that supervision occurs at regular intervals to address issues that may arise during counselling. The frequency of supervision can vary from once per week to once per month. It is usually more frequent in the initial period of our work as a counsellor while we are still building up our counselling skills.

Why is supervision important?

Supervision enables us to:

- Develop and strengthen our counselling skills;
- Ensure that we are delivering the counselling well;
- Explore issues and difficulties regarding individual patients;
- Confirms that we are on the 'right track' and doing the correct things that will help the patient;
- Provides emotional support and prevents burnout.

Supervision covers the following areas:

- Providing structured feedback and rating on individual sessions, either through listening to audio recordings or reading the transcripts
- Reviewing clinical records to assess quality of documentation and to facilitate case discussions
- Discussing problems that we have encountered while delivering counselling
- Discussing specific patients, for example difficult or interesting ones
- Referring patients to the supervisor for specialised care such as those who may pose a suicide risk or present with a personal crisis (see section on referring patients, below)
- Discussing practical difficulties e.g. time constraints, interpersonal problems with others in the health centre or personal problems that we might have as counsellors.

Who is a supervisor?

Supervision can either be given by an expert, i.e. someone who has professional training in mental health care (whom we refer to as the 'expert supervisor') or by a fellow counsellor (whom we refer to as a 'peer supervisor'). In either case, the supervisor is someone who has acquired the competency required to deliver the counselling treatment.

How is supervision done?

We will receive two forms of supervision: peer group supervision and individual supervision.

Peer group supervision

In this form of supervision, session tapes will be heard by a group of peers, each one rating our skills and providing feedback. These sessions will be moderated by one of our peers taking turns; in other words we will also play the role of moderator when our turn comes. The expert supervisor will also attend these sessions as an observer.

Peer group supervision will take place in the office every week.

Goals of peer group supervision

- To obtain feedback about the quality of counselling being provided
- To share experiences with our peers about the problems we have faced in our work and the solutions that were effectively employed in overcoming them.
- To obtain support from our peers

How to prepare for peer group supervision

- A rota of peer supervisors and counsellors whose tapes will be supervised will be prepared and circulated at the start of every month.
- We will break up into 2 groups with equal number of counsellors in each group (so about 6 counsellors in each group). Each group will have one peer supervisor and one expert supervisor. Each group will discuss two sessions: one of depression and one of harmful drinking on each day.
- All counsellors should have equal opportunities to present their tapes for both disorders (depression and drinking problems). Tapes should reflect the different phases of treatment and the audio quality of tapes should be satisfactory

If our tape is being heard, we must be prepared with the following in advance of the supervision session:

- The audio tapes should be labelled correctly and downloaded on the office laptop that will be used for the supervision session
- It is essential for us to listen to our own tapes before the supervision session and rate ourselves beforehand using the rating scale for that disorder
- Record and document the details of the session with this patient, in the light of the overall case history of the patient, and identify any difficulties that we faced. We need to make a list of these problems, detail the methods that we used to overcome these problems and record why we thought these worked or did not work in the way we had hoped. This will help us focus on the problem and discuss possible ways to solve them with our peers.

The copies of rating scales to assess the quality of the counselling session must be available for all the participants. These rating scales ([QHAP](#) and [QCAP](#)) are described in the HAP and CAP manuals.

What to do during peer group supervision

- The counsellor whose tape is being heard provides a brief description of the patient and the process of counselling until the current session (if a session other than the first session is being rated).
- While the tape is being heard, the peer supervisor will moderate the session by stopping the tape at appropriate times to generate discussion and to ensure all group members contribute to the feedback/discussion. The peer supervisor ensures feedback is given in a constructive manner.
- During this time it is important to discuss aspects of the counselling we had difficulty with and seek other ways in which we may have approached the patient's problems so that the counselling could be more effective
- At the end of the recording, our peers and expert supervisor will rate the session independently (i.e. without discussing the ratings until they have been completed), and then discuss their rating to provide feedback as well as to identify and discuss discrepancies in individual ratings.
- In addition, the expert supervisor provides feedback on both the process of supervision as well as the clinical issues at the end of the session and helps to address any issues that were not resolved during the peer supervision

- Thus, the process of peer supervision is an important way of building skills for both the counsellor whose session is being supervised and the peers who are supervising and rating the session.

Individual supervision

This form of supervision will occur on a one-to-one basis when our expert supervisor will make visits to the PHC where we are working. This form of supervision usually takes place at a minimum frequency of once a month.

Goals of individual supervision

- To provide guidance in dealing with individual patient issues ensuring safety of patients and specialist consultation when needed
- To ensure we are tracking each of our individual patients to the goal of treatment completion
- To provide support in our work in the clinic and troubleshoot any problems that we may experience
- To ensure the documentation is of good quality and completed in a timely manner

How to prepare for individual supervision

- Ensure that all our clinical records are complete and up to date
- Ensure the patient register is up to date and highlight all patients whose follow-up has been inadequate and those patients who are not showing adequate improvement despite follow-up since the previous supervision.
- Make a list of issues we would like to discuss with our expert supervisor. We can divide these into patients' issues, clinic-based issues, personal issues
- If there is a patient we would like our expert supervisor to see, we need to give the patient an appointment for the time/day when we know our supervisor is visiting and remind the patient a day earlier.

What to do during individual supervision

- Go over the list of patients selected for discussion
- Go over our list of issues that we wanted to discuss with our expert supervisor
- Provide all documents for the supervisor to review

WHEN TO REFER AND TO WHOM

Some patients may need additional help to what we are providing. It is important to recognise who needs this help and when so that we can assist these patients in getting the help they require. We may need to refer them either to a community agency that will provide them with the help they need or we may need to refer them to our supervisor for more specialised counselling or medical treatment.

Referral to the supervisor

Whom to refer:

- Patients we have detected to be at a high risk for suicide – this requires an urgent referral (*Chapter 4*)
- Patients who have mental health problems apart from depression or harmful drinking. For example,
 - A patient who behaves strangely or in an aggressive manner.
 - A patient who has thoughts that seem to be unrealistic such as believing that someone is trying to kill him/her
 - Patients, especially elderly persons, who have memory problems and are very forgetful (more than just being absent-minded)

- Patients we have been counselling who worsen or do not get better in spite of their attending sessions

How to refer to the clinical supervisor

- When the referral is urgent, for e.g. a patient with high suicide risk, we should telephone our clinical supervisor to discuss the patient's problem and obtain guidance on next steps
- When the referral is not of an urgent nature, we must discuss this with the clinical supervisor at the next supervision session
- We must inform the patient (and when appropriate, the SO) of the need for referral and the procedure involved
- It is important to record the referral in our clinical notes including the reason for referral and the outcome after the referral is complete.

Referral to community agencies

Whom to refer

Many of our patients experience very difficult social problems. Guiding patients and providing information to them about the various agencies/schemes that exist and which they can access, motivates them to engage in the counselling because it helps them feel that we are paying attention to their immediate social concerns.

How to refer

Steps to follow when referring to community agencies

- **Table 7** and **Table 8** below provide a list of agencies and welfare schemes; we must add to this list based on what is locally available in our area. We must keep this list handy at all times and familiarize ourselves with the information provided.
- Establishing prior contact with the agencies in the locality and providing a referral letter (see sample, below) or making a telephone call to the agency when referring a patient will be of value in ensuring that the patient gets the help he/she needs. The referral letter should contain the reason for the referral and the nature of help sought as well as our contact details for further communication if needed
- We can also keep copies of relevant forms (for example, for application for social welfare schemes) and assist the patient to complete these when applicable.
- It is important during follow up to ask the patient about the results of the referral, so that further action may be taken if needed.

Examples of community referrals:

- A patient with a drinking problem will benefit from information about the local Alcoholics Anonymous group and a referral letter to them.
- If unemployment is a problem either for the patient or a family member, information can be given about employment agencies.
- A woman who seeks help to deal with a violent spouse can be referred to the women's support group.
- An elderly patient with financial problems can be referred for the Senior Citizen's Scheme.
- The widow pension scheme can be used for women who are widowed or separated.
- Educational schemes can be availed of to provide scholarships, books, etc. for children from poor families.

Sample referral letter sample

REFFERAL FORM

To,

Dear Madam / Sir,

Referring _____, _____ years old, residing at _____

Reason for referral:

Please contact me on Telephone No: _____ for further details if needed.

Thanking you,

Counsellor

_____ **PHC**

Table 7: List of Social Welfare schemes

Sr No	Name of the scheme
1.	Scheme for welfare of children
1.1	SaralVidyaSahay scheme to provide assistance in education to SC/OBC students.
1.2	Meritorious Scholarship for SC/OBC students
1.3	Post matric scholarship for SC/OBC students.
1.4	Books, Stationary and uniform for SC/OBC students
1.5	Book bank scheme for SC/OBC students
1.6	Bachpan
2.	Scheme for welfare of women
2.1	Widow pension
2.2	LadliLaxmi
2.3	GrihaAdhar
2.4	Self Help Groups- for women groups
3.	Scheme for welfare of disabled persons
3.1	Stipend to disabled students
3.2	Scholarship to disabled students from Std. IX onwards.
3.3	Financial assistance for self-employment to disabled persons
3.4	Dayanand Social Security Scheme
3.5	Claim of 50% subsidy for motorized vehicle on petrol/diesel to disabled
3.6	Issue of Identity cards to disabled persons
3.7	Awards for marriage with the disabled.
3.8	District Disability Rehabilitation Center Bambolim
3.9	Financial assistance to persons with severe disabilities.
4.	General schemes
4.1	Welfare of prisoners family and children
4.2	Dayanand social welfare scheme
4.3	Financial Assistance
	4.3.1:Financial assistance to vegetable and flower vendors
	4.3.2: Financial assistance to motor cycle/ taxi, rickshaw/ owners (repairs)
	4.3.3: Pension for motor cycle pilot
4.4	Housing Schemes
	4.4.1: Indira AwasYojana
	4.4.2: Rajiv AwasYojana

Table 8: List of Referral Agencies

Sr No	Referral agencies
1	HIV/ AIDS
2	Drug and Alcohol problems
3	Short stay shelter homes for women and children
4	Shelter for elderly
5	Resources for severe mental illness
6	Counselling centre
7	Children with problems
8	Legal aid
9	Orphanages
10	Special schools

KEEPING CONTACT WITH PATIENTS AND ENCOURAGING TREATMENT COMPLETION

When is treatment completed?

A major challenge in counselling is to ensure that patients attend for all of the treatment. This involves the patient:

- Attending counselling sessions regularly as scheduled
- Performing tasks or exercises between sessions as planned with the counsellor

Why is treatment completion important?

The main problems that arise due to non-completion of treatment are inadequate improvement and a relapse of the problem – sometimes patients stop their treatment prematurely when they feel better. They stop making the changes that are necessary to ensure that they have fully recovered from their problem this could lead to the problems increasing again and loss of the gains achieved in counselling.

Our patients will complete their treatment if our treatment is:

- **Accessible:** If patients live very far from the clinic, they are likely not to return. Home visits and telephone sessions, and timing any clinic appointments when the patient needs to visit the PHC for other reasons, are ways to achieve this goal.
- **Acceptable:** i.e. patients feel that the treatment is easy to follow and meets their expectations. Using simple language and practical suggestions are key ways to achieve this goal.
- **Effective:** It helps the patient feel better and solve his/her problems. Thus, being skilled in delivering the treatment and ensuring we get advice from our clinical supervisor or peers if the patient is not improving are ways to achieve this goal.

What are the steps we can take to ensure patients receive the complete treatment

- Choose the setting/format for treatment delivery that the patient is most comfortable with i.e. home/PHC/ telephone. We may need to use these methods in combination for some patients since at different times they may prefer different methods.
- If the patient has given consent for home visits, use this as the preferred mode of treatment delivery as this will solve many practical difficulties the patient may have in visiting the clinic.

- If the patient is not willing for home visits, fix appointments to suit the patient's convenience and be flexible. For example, if the patient is unable to set a fixed time/date for the appointment, we can ask them to return anytime in that week, telling them the hours when we are available in the clinic.
- Remember we can also use alternative locations for sessions, for e.g. a community centre, if this is more convenient for the patient.
- Try and arrange appointments when the patient is due to visit the PHC anyway to meet the doctor
- Maintain a diary (we can use our smartphone!) to schedule the next appointments. This can be used to track when the patient is due for the next session as well as when we need to send a reminder to the patient. (Details to be added later)
- Maintaining a patient register which you can check every week to see whether any patients have failed to attend their scheduled appointments.
- Making a telephone call to remind the patient about a home visit or when they are due for their appointment. If the patient is not available for a session at the time of the home visit or fails to attend a scheduled appointment at the PHC, we should telephone the patient within a week to reschedule the appointment. If it is more convenient for the patient, we can also use this opportunity to conduct the session on the telephone.
- If the patient doesn't answer the phone, we can send a text message to their mobile number
- If the patient is unavailable on the phone, and has provided consent for home visits, we can visit the patient anyway to conduct a session
- Involving an SO in ensuring that the patient attends each session and undertakes the tasks in between sessions can be very useful. The SO can help by:
 - Accompanying the patient to the PHC
 - Taking care of dependents at home while the patient visits the PHC or while we are conducting a session at home
 - Reminding the patient of their next appointment and encouraging them to attend
- Continue the treatment of patients return after a long break. Sometimes, patients we have discharged due to their failure to return for sessions may contact us or come to us after a long gap. In such situations, we can continue the treatment and provide the remaining counselling sessions while addressing the reasons for failure to return.

The table below summarizes the most common reasons why patients do not attend or complete the treatment along with possible solutions.

Table 9: Barriers to treatment completion and possible solutions

Barriers to Treatment Completion	Possible Solutions
Practical Barriers	
Lack of time: Patients are working as daily wage earners and do not have the time to come back to meet with the counselor or they have caregiving responsibilities and cannot leave home.	Offer home visits as the preferred option and fix a time that is convenient for the patient to visit their home and conduct the session. We also need to explain to the patient that he or she is available for consultation in the afternoon as well and that the patient can come at a convenient time later in the day before the clinic closes. Plan follow-up sessions according to patient's convenience (e.g. when he/she has an appointment to see the doctor, or is coming to the area of the clinic for some other reason). Conduct telephone sessions
Travel cost	Home visits; Link patient appointments to other visits to the

	clinic; telephone counselling
Patients forget about the date when they are supposed to come back for the next appointment.	We should write the date clearly in the appointment card and the relevant section of the patient booklet and tell the patient that if for some reason they cannot make it on that date they are still welcome to drop in for the appointment on another date that is convenient for them. Make a telephone call prior to the date to remind the patient of the appointment to all patients.
Cultural/psychological barriers	
Patient feels that their health concerns and social problems are not being addressed	Be familiar with the other physical health problems the patient is suffering from and ask about this at each session; this will help the patient feel that you are concerned about all health aspects. Be sensitive to patient's social problems, listening to these problems, advising patients about what to do and writing referral letters to relevant community agencies and following this up will help improve engagement
Patients drop out of treatment when they start feeling better	During the first session, we should clearly explain the importance of following through with treatments even after the patient starts feeling better for the best results. We can say <i>"It is possible that you may feel better after a couple of sessions. However, it is important to attend all the sessions and take the complete treatment for best benefit. Take the example of TB-although the course of tablets is for six months, most patients find that their fever subsides in one or two weeks and they often stop the treatment early, but the TB is not cured and can even get worse. Similarly, if you stop this counselling too soon, it is possible that your problems will return"</i> .
Patients do not feel they have a 'mental health problem'	NEVER use the term 'mental' while explaining the nature of the problem to patients because it is associated with shame and fear It is best to use the term 'stress or tension related' when explaining the nature of the problem to patients as this is something that patients can identify with easily and do not feel a stigma attached to it.

How does counselling end?

There are various ways in which the counselling sessions can come to an end and we discharge the patient from the program. Most often, this happens when the treatment is complete. This is called a planned discharge. This happens when all the phases of the counselling have been delivered and the goals of treatment have been achieved. The end of counselling is decided upon collaboratively by the patient and we also discuss this with our supervisor, if needed. Counselling may also end in other circumstances such as:

- **Drop out:** the patient fails to follow up for an appointment or refuses further counselling sessions. If we have made a minimum of two attempts to contact the patient (as described above) but have failed to do so, we may discharge the patient one month after the last missed appointment.
- **Referral out of the program:** Sometimes, the patient may have a problem that requires specialist or other forms of treatment (for example, a patient with odd/psychotic

- symptoms). The patients are then provided the appropriate referral and discharged out from our care.
- **Death:** A patient, who dies during the counselling program, is discharged. If a patient who has dropped out of treatment returns to seek counselling again, we can reopen the patient's file and continue counselling from the point at which they dropped out. Similarly, a patient who has completed treatment and had a planned discharge may return on his/her own for further counselling. Such patients may re-enter treatment at this point. It is good practice to discuss such patients with our supervisor.

MAINTAINING STANDARDS – DOCUMENTATION AND RECORD KEEPING

It is important that we give adequate attention in completing the supporting documentation or the recording of information related to patient sessions. This captures the essential details of what occurred during the session i.e. the clinical and social problems that the patient presented with and the advice that we provided. The nature of the documentation is different depending on whether it's the patient's first visit or follow-up and the Clinical Case Record for [depression](#) and [alcohol problems](#) will enable us to record the relevant information.

Why is documentation important?

It is important for us to understand the importance of adequate documentation. Some of the more important reasons are given below:

1. Keeping track of the clinical process for each patient in the program:

The clinical record is useful for us to refer to when the patient returns for follow up. When the records are maintained properly, they enable us to focus on the relevant details and make the best use of our limited time.

Since we will be seeing a large number of patients, it is impossible for us to remember their individual problems and personal details. A good quality clinical record will tell us what were the symptoms that the patient had presented with, what was the nature of counselling treatment that we had carried out and the tasks that both had agreed on during subsequent sessions. This baseline information allows us to monitor the progress of the patient accurately and will also make the patient feel that her concerns are being addressed in a systematic manner.

The clinical case record is also an indicator of the process of treatment i.e. it provides a summary of the type and details of the treatment provided. This will help us evaluate whether the goals are being met.

2. To make supervision effective:

The quality of the clinical record has a direct relationship with the quality and agenda of the supervision process by making it very focused.

Correct documentation will ensure that the counselling treatments are being followed in a systematic manner. For example, if a patient is being referred to our expert supervisor, the reasons for that decision need to be detailed so that our supervisor can judge whether the decision is appropriate.

Clinical records are a very useful way of monitoring the overall quality of any health program.

The records that we will need to fill at each session is:

1. **The clinical record form** for [depression](#) and [alcohol problems](#) – there is a separate one for the first session and for subsequent sessions
2. **The patient registers** for [depression](#) and [alcohol problems](#).
3. **The appointment diary.** This is entered into our smart phone (to be described)

4. **When we discharge a patient**, the end of treatment form for [depression](#) or [alcohol problems](#) is completed

Points to remember:

- Records must be filled as soon as the session is over and definitely by the end of the day so that important details are recollected.
- It is important to store the records in a safe and secure place i.e. a drawer/cupboard with a lock. This is necessary to protect patient privacy and confidentiality.
- Review the records prior to our session with the patient to remind us of what has been discussed

MAINTAINING BOUNDARIES

What are boundaries?

Boundaries are limits within which the counselling relationship functions. They may be seen as rules that are part of the counselling treatment and it is our responsibility to maintain them.

Why do we need boundaries in counselling?

In a counselling relationship, there is a risk, due to the personal nature of the topics discussed, that the professional relationship may be breached.

Boundaries are important to define counselling as a professional relationship between us and the patient that is different from a conversation with a friend or family member. They help to ensure the safety of both ourselves and the patient.

What sorts of boundaries are important for us to maintain?

- Arranging sessions with patients in places other than the clinic or a planned home visit

One of the important aspects of maintaining a professional relationship is to, as far as possible, see patients only in the home or the clinic. This helps both us and the patient to recognize that we are meeting for a specific purpose that is related to the patient's problem. In some cases this boundary can be broken and a session conducted in a different setting such as a restaurant, but this must be considered a rare occasion and discussed with the supervisor. However, extra care is needed in such meetings to maintain the professional stance of the counsellor, as the example below illustrates.

Example: A counsellor was not able to accommodate a patient on a particular day when the patient really needed to see her because of a busy schedule. As an exception she agreed to meet the patient at a restaurant on the way home in the evening. This session was very different to the sessions conducted in the clinic as it started with a casual exchange over a cup of tea. The patient became very curious about the counsellor's life and started asking personal questions. It was very difficult for the counsellor to handle this situation and not much was achieved in terms of discussing the patient's problem.

In such a situation, the counsellor could have said to the patient *"I realise this is not the usual place we have our sessions but it will help you if we discussed the various items on our agenda rather than speaking about me. Remember, these sessions are to help you get better"*.

Sometimes, we may meet a patient accidentally, such as in a shop or a restaurant. This can be tricky since the patient's confidentiality may be at risk and they may not want others to know they are receiving counselling. It is good practice to discuss this possibility with the patient at the first session and ask them how they would like us to respond if we meet outside.

- Exchanging personal phone numbers, receiving telephone calls

An appropriate balance is required so that the patient has access to us but in a structured manner. We must give the contact number that is the official number and clearly indicate the most appropriate timings when it is convenient for us to receive a call; and at the same time, we must assure the patient that he/she may call us in case of emergency or personal crisis.

- Touching, physical contact

There are many cultural factors that need to be kept in mind which considering the issue of touch or any kind of physical contact in a session. For instance, it would be inappropriate to touch a patient of the opposite sex.

Some counsellors feel that there are instances where light physical contact may be helpful (for example, placing a light hand on the hand of the patient who is in a very distressed). However, in general, other ways of showing care are more appropriate – such as bending forward and softening one’s speaking tone, both useful ways of indicating care without physical contact.

- Exchanging gifts

Patients may bring gifts for us as a way of appreciation for all the help. Also, because of the nature of the relationship, patients feel close to us and wish to give us something. We must be thoughtful about receiving gifts, i.e. while not hurting the patient’s feelings, ensuring that the gift is appropriate, for example, not expensive and beyond the patient’s means and also not a frequent/regular occurrence. If we think there is a risk of breaching the boundary of a professional relationship, we may explain to the patient that because of the professional nature of the relationship, it is not appropriate to accept the gift and that this is a standard procedure that applies to all patients. It is always wise to seek consultation from your supervisor if you are uncertain about receiving a gift.

- Time-related boundaries

Setting time limits to sessions helps to keep the session in focus and allows for maximum productivity. Too short or too long sessions can be unhelpful. If sessions are too short the agenda may not be covered and the patient might not be effectively helped. On the other hand if sessions carry over beyond the time limit there is a risk of things being repeated and too many issues discussed that cannot be addressed all together, quite apart from this interfering with our ability to attend to other patients.

- Dealing with personal questions

Since patients share a great deal of personal information with us they often feel the need to know more about our personal lives. They may ask questions that will help them get to know us better.

All information that is related to the professional aspect of the counsellor like training and experience is an area that the patient has a right to know. Apart from that, patients can be explained that personal information is not really relevant as we are professionals who bring skills to the session and it is these skills that will help the patient rather than our personal information.

- Counselling patients of the opposite sex

Issues related to interpersonal boundaries described above can acquire very different connotations when they are considered in context of counselling patient of the opposite sex. Exchanging personal details, physical contact and time related boundaries can acquire altogether different meaning in context of counselling patients of the opposite sex. Hence it is important to take extra precautions about keeping boundaries in this situation. When counselling patients of the opposite sex, it is important to keep both our and the patient’s comfort in mind. Female counsellors may feel unsafe visiting the home of a patient of the opposite sex. In such circumstances, a male member of the team such as a health assistant can accompany the counsellor.

A female patient may feel uncomfortable being visited by a male counsellor. To avoid discomfort to the patient, ensure that there are other family members at home when you plan the visit. Also, a female health assistant can accompany the counsellor when possible.

Taking care of ourselves

What is burn-out?

Burn-out is a state of emotional, mental, and physical fatigue caused by prolonged stress. It occurs when we feel overwhelmed and unable to handle the emotional burden of our position as a counsellor. As the stress continues, we begin to lose the interest or motivation that led us to become a counsellor in the first place.

Burn-out reduces energy levels and creates feelings of helplessness and hopelessness. Eventually, we may feel we have nothing more to give, which can lead to negative effect with patients.

Most people have days when they feel bored, overloaded, or unappreciated. But when potential harm to patients becomes a factor, the situation must be addressed.

Causes of burn-out

There are a number of causes of counsellor burn-out such as:

- Giving a great deal of our emotional and personal energy to patients without any positive feedback.
- Being under constant pressure (either from the patient or our supervisor) to produce results in an unrealistic time-scale.
- Working with many difficult patients at the same time, for example those who have very serious social problems or who show little/no improvement despite our best efforts.
- The absence of support and trust from our peers and supervisors or, instead, a lot of criticism.
- Having few opportunities for training, continuing education, supervision or support.
- Having unresolved personal problems which interfere with our ability to be effective, for example, marital or health problems.

Preventing burn-outs

Burn-out can be avoided by taking *personal responsibility* for our own well-being. Rather than blaming 'the system' or 'the organization' or 'the lack of local training opportunities', we need to help ourselves to avoid burn-out.

Some or all of the following may be useful

- Attempt to improving our skills continually by reading this manual, attending training and workshops when possible and making the most of supervision.
- Stop taking on more responsibility than what belongs to us as a counsellor. It is important to stop thinking about patients' problems and 'switch off' when we leave the clinic
- Improve our surroundings. Tidy up our work area, put colourful posters on the walls, put up colourful curtains
- Attend to our own physical and mental health through adequate rest, sleep, diet and exercise. When we feel stressed, we can practice the breathing exercise regularly. This is described in the HAP manual (**Chapter 5**)
- Develop hobbies and interests outside work.
- Sharing and socialising. We must take time to share our feelings and experiences with our family and friends. We can receive support by discussing problems we face at work during our peer group supervision or in private with our expert supervisor. (*Chapter 6*)

Here is a brief description of how Pankaj, a full-time counsellor, seeks to avoid burn-out:

'First of all, I control my workload. I know that I cannot see more than five patients a day and adequately report on my contacts with them. As I work best between 8 am and 2 pm, I schedule my patient sessions during these times. I also do my documentation then, keeping 2 to 5 pm to

myself, when I usually have a brief rest or go for a walk. I eat well in the evenings and at breakfast, so I have a light lunch and never miss meals.

Next I make sure that I only talk about my work with my supervisor and a peer I am close to and to whom I can comment about mistakes as well as successes. I also know that I can learn from them, since they share their own experiences of helping with me, honestly and warmly.

Finally, I pursue my hobby regularly ... I enjoy listening to music and I also sing quite well. I have begun to attend singing classes in my neighbourhood once a week and spend one hour every evening practicing my singing”

SUMMARY

- Regular supervision by either our clinical supervisor or peers, individually or in a group, will help support us during our work and ensure we deliver good quality counselling to our patients
- Sometimes it is necessary to refer patients to our supervisors for further management especially those with high suicide risk or who don't improve with counselling. Patients in difficult social situations can be helped by referral to appropriate community agencies
- Ensuring that patients complete treatment is very important to ensure the best results of counselling. Telephone counselling is a useful alternative to face to face counselling and can be considered for patients who are unable to follow up for subsequent counselling sessions at home or in the clinic. Prior consent must be taken for this
- Documentation of counselling by completing clinical records after each session is important to keep track of the clinical process and to make supervision effective
- Maintaining boundaries in the counselling relationship helps to ensure that the professional nature of the relationship is maintained
- Being aware of the risk of burnout and taking precautions to prevent it are important in our work as counsellors

APPENDIX 1

Glossary of difficult words

Difficult words	Meaning
Abuse	To hurt, injure
Affirmation	To declare one's support for a person's action
Assess	Evaluate, examine
Barriers	Obstruction, Anything that makes it difficult to progress or achieve something
Burnout	Physical or mental fatigue caused by overwork or stress
Chronic	Constant, long-standing
Collaborative	Two or more parties working together
Competency	Ability to do something well, capability
Confidential	To keep information given to you as private or secret
Consultation	Meeting, session, a meeting with an expert, such as a medical doctor, in order to seek advice.
Counselling	Helping and guiding patients in resolving their problems through an interactive learning process
Discomfort	Uneasiness, Not comfortable
Disclosure	Making new or secret information known
Empathy	The ability to understand and share the feelings of another
Empower	Make someone stronger emotionally or more confident
Engage the patient	Cause the patient to become involved in counselling
Flexibility	The ability to be easily modified, elastic
Isolation	Loneliness, alone
Judgmental	To pass judgment, critical
Optimism	Hopefulness, expect the best and see the best in all things. To be hopeful.
Peers	People who are similar to you in age, experience, background, etc.
Reassurance	To remove someone's doubts or fears
Referral	Pass on care to someone else usually a specialist
Self esteem	Self-respect
Significant other	A close friend or family member who can play important role in the treatment
Stigma	Social shame or disgrace
Transcripts	A written or printed version of material/Session

APPENDIX 2

Suggested further reading

Although this manual covers everything that you need to know to develop and deliver an effective counselling relationship, you may want to read more about this area. There are some suggestions for further reading below.

- Egan, Gerard (2010) *The Skilled Helper: A Problem-management and Opportunity Development Approach to Helping* (10th Edition). California: Brooks/Cole
- Nelson-Jones, Richard (2010) *Theory and Practice of Counselling & Therapy*. 5th Edition. London: Sage Publications
- Patel, Vikram (2002) *Where There Is No Psychiatrist: a mental health care manual*. London: Gaskell
- Velleman, Richard & Aris, Sarajane (2010) *Counselling and Helping: Psychology in Action*. London: Wiley Blackwell / British Psychological Society