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2 Off the Record
Veterans and Insomnia: A Clinical Intervention Case Study
Neil Duchac and Mindy Heher

4 Dusk to Dawn
Separate But Equal: Working Well with Others
Rosanne Nunnery

6 Behind the Curtain
Reflections of a Deployed Counselor: Responding to the Las Vegas Mass Shooting (Part II)
Rebecca Cowan

8 Hushed Tones
Transitioning from Graduate Student to the Novice Therapist: Learning the Importance of Self-Care
Nicole Benton and Alyssa Weiss-Quittner

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Off the Record: Insights for the Clinical Supervisor

Delve into the professional practice of clinical supervision by exploring ideas, best supervision practices, and reflections from experienced clinical supervisors

Veterans and Insomnia: A Clinical Intervention Case Study

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Heher, Duchac and Frye (2018) discuss sleep disturbances and how they impact those who served or are currently serving in the military. This brief article presents a typical case encounter between a veteran and a counselor utilizing a Cognitive Behavioral Therapy- Insomnia (CBT-I) approach. Kathal and Arnedt (2016) discuss the utilization of CBT-I from a pragmatic standpoint, in terms of its short duration (typically, 6-8 sessions) and the perceived efficacy of this approach, benefitting an estimated seventy to eighty percent of clients. This success is without adjunctive medication. The utilization of CBT-I should be evaluated as a first line treatment intervention. Additionally, CBT-I was selected here due to the authors' specialization in this area and the efficacy of such an approach based upon clinical experiences.

Case study

John is a 42-year-old recently retired U.S. Army Master Sergeant. During his 23 years of service, John served four tours of duty in a combat zone that included one year in Iraq and three years in Afghanistan. In addition to his combat tours, his family moved to eight different duty stations. Following his retirement, John, his wife Brittany (42-years-old), and his children John Jr (16-years-old) and daughter Aryanna (11-years-old) moved back to Ohio to be closer to family members. John and Brittany have been married since graduating high school and have a strong and supportive relationship.

Following a distinguished career, John was very excited to retire and begin his new career in real estate. Ninety days post retirement, he visited his counselor for disturbances with his sleep. He reported he had been sleeping only a couple of hours each night and had difficulty both falling and staying asleep. He did not appear depressed or anxious. Additionally, he did not report any symptoms commensurate with the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). John reported his lack of sleep impacted his familial relations in terms of his level of stress and frustration.

The following is a session-by-session illustration of how clinicians could conceptualize working with this client. Perlis, Jungquist, Smith and Posner (2005) suggest CBT-I is typically four to eight weekly treatment sessions.

Sessions

Session 1: In his first session, John's counselor completed a comprehensive assessment of John's current sleep problem and gathered information about his medical and psychiatric history. John completed a battery of sleep assessments prior to his initial session. Once the counselor determined John met diagnostic criteria for Primary Insomnia and was a candidate for Cognitive Behavioral Therapy for Insomnia (CBT-I), time was spent educating John about CBT-I and answering his questions. John's counselor introduced him to the sleep diary and asked him to record his sleep hours and sleep experiences via the diary as homework.

Session 2: In the second session, John's counselor immediately reviewed John's sleep diary with him and evaluated his compliance with the homework assignments and commitment to treatment. During this session, sleep restriction (SR) and stimulus control (SC) were introduced to John. Based on his sleep diary data, John's prescribed good night and good morning times were determined. John's counselor created a specialized treatment plan for John determined by his sleep assessments and verbal report. John was assigned homework that included the sleep diary, SR and SC.

Session 3: John's counselor spent time reviewing John's sleep diary at the beginning of the third session. Clinical adherence and problems associated with the treatment were discussed along with problem solving. Contingent on clinical improvements, John's sleep schedule was upwardly or downwardly titrated. Sleep hygiene instructions were provided during the session. John's counselor also introduced progressive muscle relaxation (PMR) training and practiced using this relaxation technique with John during the session. John was given a sleep hygiene handout, instructed to use PMR each evening prior to sleep onset, and asked to record his sleep experiences in his sleep diary until the next session.

Session 4: Session 4 began with a review of the previous week's sleep diary. John and his counselor spoke about treatment compliance and addressed any issues. Adjustments to John's sleep schedule were made per his sleep diary data and self-report. Depending on clinical improvements, John's sleep was upwardly or downwardly titrated. Cognitive therapy was utilized to target cognitive distortions or maladaptive beliefs about sleep. In addition to his weekly sleep diary and PMR, John's homework included keeping a thought record to help change his dysfunctional thoughts about sleep.

Session 5: Session 5 started with a review of John's sleep diary and thought record. Titration of sleep continued based on clinical improvements as determined by the sleep diary and John's report. John's counselor discussed his compliance with treatment. John's homework included the sleep diary, thought record, and PMR at bedtime.

Session 6: During the final session, John and his counselor reviewed John's sleep diary and thought record as warranted. The focus of this session was relapse prevention. John and his counselor reviewed treatment improvements. They discussed a relapse prevention plan.

Conclusion

Though not specifically addressed due to the brevity of this case study, Vitiello, McCurry, and Rybarczky (2013) note the positive and conclusive impact that CBT-I has, in terms of treatment with complicated and uncomplicated insomnia. Through their research, they examined the utilization of CBT-I and have proposed three recommendations, including: increasing treatment efficacy for clinical outcomes, increasing treatment effectiveness for use in the community, and increasing practitioner training and dissemination. As you have read through this case study, it is important to know that it provides only a very short synopsis and that there may be many variations and complications, which could not be addressed due to the short nature of the article.

Dusk to Dawn:
Gradually visible trends in counseling & psychology

Engage in an exploration of ideas and thoughts that illuminate future evidence-based therapies, techniques, theories and interventions in the fields of counseling and psychology

Separate But Equal: Working Well with Others

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Counselors, psychologists, social workers, and marriage and family therapists have personal and professional identities. All helping professions work within their paradigm yet are required to collaborate with other helping professionals to effectively serve clients by bringing a variety of professional perspectives and worldviews. When asked to come together as a treatment team on behalf of clients, conflict and resistance may occur. What if a team adopted a dialectical framework to create a middle ground (Linehan, 1995)? A place where varied opinions are embraced yet an opportunity to grow and change perspectives emerge. In dialectical behavioral therapy, an effective team requires an understanding of dialectics, a structured treatment team approach while balancing accountability and validation among members.

Knowing that dialectical beliefs are the core to dialectical behavioral therapy (DBT) treatment teams; clinicians need to metaphorically eat, live and breathe the concepts that underline this treatment to trust the process. How is this accomplished? DBT counselors and treatment team members must believe that people do want to change, and that change is inevitable. Humans engage in life using emotions and thoughts, and by possessing an internal sense of knowing. This intuitive knowing, called wise mind, can be a catalyst to group decision making (Linehan, 1993). Ethical standards (ACA, 2014) emphasize the use of radical acceptance of others with a commission to do no harm. Linehan (2002) emphasizes an acceptance of the person, the moment, and the experience. To hone these abilities, DBT encourages humility and honest recognition of the power of interaction while engaging at a humanistic level with one another no matter titles or degrees (Linehan, 1993). Just as there is a practice of humility, there is ongoing validation along with accountability and behavioral contingencies (Linehan, 1993). There is power in acceptance of a person's pain while expecting adherence and consequences for non-adherence to those expectations. When paired together, they are a beautiful marriage. Establishing and adhering to all of these fundamental ideals helps guide the rationale and structure of a DBT team.

With a dialectic viewpoint, team members choose to have an authentic and supportive environment where DBT assumptions are adhered. Assumptions are beliefs acted out on purpose and in DBT treatment teams, assumptions are not true or false, nor right or wrong. Members are trained to check personal assumptions, adapt myths about clients and clinicians and accept humans as humans with fallibility. Some of these ideological assumptions involve understanding that people want to improve, everyone deserves respect as a basic human right, people are doing the best they can, pain and stress are all part of life, and people cannot fail (Linehan, 1993; 2016). Assumptions are considered prior to forming an effective treatment team.

The New Mix

Our changing world practically requires technological competency. Stay up-to-date with software, apps, programs, and other advances.

QUARTERLY SPOTLIGHT:

Digital Ethics *by*

ZUR INSTITUTE

The Zur Institute offers a variety of resources to aid in the new digital frontier. This article walks through the question of whether or not a counselor should accept a friend request on Facebook. It offers helpful tips to consider with living in a digital era:

https://www.zurinstitute.com/clinical-updates/facebook-friend-request/

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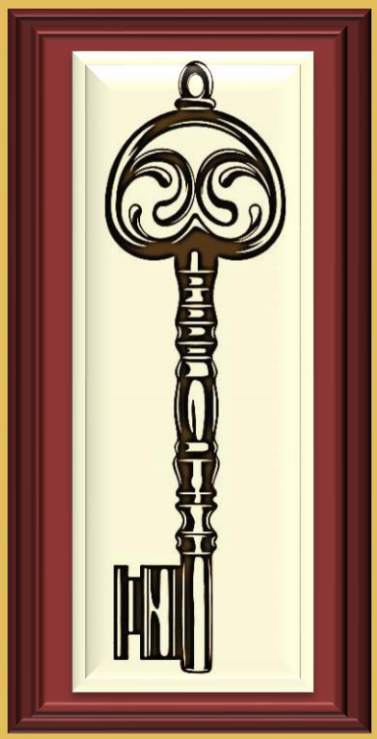
So, why have a treatment team? Across clinical programs, weekly team meetings are common. They are designed to go over client cases, offer supervision and consultation, and evaluate treatment progress. In DBT, the rationale for treatment team meetings is to have specific and scheduled opportunities to review DBT strategies and skills, exchange information, and give and receive support to avoid burnout. To form a team, there needs to be at least three team members and one team leader, including a case manager, medical professional, skills trainer, teacher and counselor (Lienhan, 2015). To start a team, it is imperative that all members agree on a unified team contract and list of DBT agreements that govern each meeting. Some fundamental elements of a contract includes: acceptance of a dialectical philosophy, honesty about therapy interfering behaviors, nonjudgmental interactions, acceptance of fallibility and accountability, and shared responsibility among members. Now that a treatment team has been established, the identified roles should be explored.



Within an hour and a half treatment team meeting, each member has a role to play. The designated leader, typically the seasoned counselor, guides the meeting and can be a rotating position. The leader rings a bell to start the meeting and reads one of the agreements from the contract such as “we accept that counselors are fallible.” After the agreement has been read, the team leader starts the meeting and guides all members through a mindfulness activity providing centering and focus in the present. Once mindfulness is over, one team member is designated the observer whose purpose is to watch for adherence and has the task of stopping the meeting. This happens for a variety of reasons including being late, not adhering to dialectical principles, or for judgmental statements. Once the bell sounds, the observer explains the observed behavior and seeks to find the middle ground. No matter the member or perceived status, all members are held accountable to the principles (Linehan, 1993; 2002, 2015). Each client’s case is discussed, and all members communicate. In DBT treatment teams, all members explore and agree upon the course of action. When exploring client treatment, perceptions of interactions and issues that emerge; there is a continued balance with acceptance and validation along with behavioral accountability. For example, a skills trainer might conclude that a “client just does not want to do this treatment because she never attends a group.” The observer might indicate, “I understand your frustration with the client due to her lack of attendance but let’s consider the client’s behavior and your frustration with her.” While the counselor might indicate, “we have specific accountability rules about missing group so if she chooses to not attend, she will have to start the cycle of skills group over.” The ability to look at all clinical perspectives provides an environment where all members can be authentic regarding both client and clinical staff. There is a balance of validation and accountability. As a result, all members are separate but equal and capable of interacting effectively. This model is one that can be applied across all settings creating support, mentorship, and internal consistency.

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Behind the Curtain

Explore the experiential world with thoughts from the counselor's couch that speak to the heart of practice

Reflections of a Deployed Counselor: Responding to the Las Vegas Mass Shooting (Part II)

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Two weeks after deploying to the mass casualty incident in Las Vegas, Nevada I returned to my home in Virginia--with many mixed emotions. I was fine, at least that was my initial thought. After all, I had been in the mental health field for years now---both teaching and in practice. I should be able to handle this level of trauma. I quickly shifted my time and energy towards work, partially because I had fallen behind while deployed and needed to catch up. I did not leave my house for a week. Reminders of Las Vegas were all over the news and social media. Everyone was talking about it. I literally could not escape. I was having trouble concentrating, which caused longer completion time for tasks. I remember opening Facebook and seeing a news story with pictures. I recognized the victim's face immediately. The face of the man whose hand I had held in the hospital. Anxiety hit. I could not find a place to escape the memories of my work in Las Vegas. Even mindless activities such as Facebook, became triggers.

I started to recognize the different impacts of my work as a disaster mental health responder and my typical work in private practice. I was well-versed in the self-care strategy of not allowing work to follow me home. However, the videos and images of people being shot in Las Vegas were literally being broadcasted into my home. The victims on the news were not strangers to me---they were my clients. In private practice, I had become accustomed to hearing graphic and traumatic stories—however, I had never actually had the visual image of the experience. This was new to me.

Knowing I had not left my home in a week, my friend called and asked me to take a walk with her at the beach. I was hesitant at first but did eventually agree. I remember what a contrast it was to be there. The soft waves rippling into the shoreline. I was surprised by feelings of guilt. Here I was standing on this peaceful beach while so many lives had been destroyed just a few weeks prior. While walking and talking with my friend, I shared more about my experiences but quickly felt misunderstood.

WORDS OF WISDOM

Counselor meditations for daily clarity

To live is to suffer, to survive is to find meaning in the suffering

Viktor E. Frankl

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This feeling continued with friends as their responses were dismissive and confused, “Why are you feeling this way? You weren’t actually at the shooting.” I shut down.

I needed a safe space to process, without judgement, and so I decided to address my experience in therapy. With the help of my therapist, we slowly unraveled the cognition that Vicarious Trauma indicates incompetence. I began to accept this but did not actually believe it until many months later when I was called to the Parkland, Florida school shooting in February 2018. It was there that I reunited for the first time with many of my colleagues from Las Vegas and while driving to the scene one of my colleagues stated that she had a really difficult time after the Las Vegas shooting. I perked up looking for any validation I could find that what I had experienced maybe was normal. She stated, “I didn’t leave my house for a week.” The other colleague chimed in, “I felt like something was wrong with me”. I cannot describe the level of relief I had. If only I had connected with them sooner. For months, I had felt so isolated. We exchanged contact information during our time in Parkland and vowed not to lose contact once we returned home. The connection with these colleagues exists to this day.

I later found that isolation in this type of work is incredibly common. Due to the parameters we have around confidentiality, we cannot expect our loved ones and colleagues to fully comprehend the “depths of suffering that our patients experience” (Quitangon & Evces, 2015, p. 146). This is one reason peer consultation has been found to serve as a protective factor against vicarious trauma (Harrison & Westwood, 2009) and is an important part of the process. This experience has made me recognize that our work as trauma counselors is not only with our clients—but also with ourselves.

I have been called to four mass casualty incidents since Las Vegas and, unfortunately, I know there will be more. Responding to these events has been an important part of my journey as a counselor. It has helped me to see the world in a different way---one that was darker during those first few weeks of returning home—but now I can clearly see how beautiful and healing human connection can be.

My hope is that by sharing my experience, future disaster response counselors will know that they are not alone and can reach out to colleagues and their own personal counselor, if needed. This experience has certainly increased my awareness of just how strong counselors are by responding to these types of tragedies and putting themselves at risk of developing their own vicarious trauma. It has also shown me that seeking help does not indicate weakness, but that our own healing is what strengthens our ability to competently engage in this type of work.

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Hushed Tones

Soothe your self with discussions on caring for the counselor, self-care and related thoughts

Transitioning from Graduate Student to the Novice Therapist: Learning the Importance of Self-Care

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There are many emotions, thoughts, and processes that go into making the transition from a counseling student to a practicing professional. Many therapists can recall this time as exciting, overwhelming, and a bit scary. Therapists are anxious to apply the knowledge learned in graduate school to an actual client. Graduate students are exposed to the theories and current approaches of the counseling profession. However, many graduate programs need to implement further discussion on self-care, particularly for the novice clinician. As Kissil and Nino (2017) assert in their article, self-care may be considered an ethical mandate for the practicing clinician, particularly as it relates to the respective Codes of Ethics. According to the American Association for Marriage and Family Therapy Code of Ethics, Standard three discusses professional misconduct, warning therapists to not practice therapy if they are impaired by mental causes (AAMFT, 2014). In section A.4.a in the American Counseling Association's Code of Ethics, it is written that counselors should ensure that clients are not harmed and to make attempts to avoid or remedy any harm or potential harm (American Counseling Association, 2014). These codes do not implicitly mention self-care as an ethical mandate; however, therapists can recognize it is in the therapist's best interest to practice self-care. Essentially self-care allows clinicians the opportunity to remain true to their respective ethical codes and maintain professional competence.

The concept of self-care is crucial for the novice therapist. Research has shown that neophyte clinicians are often at higher risk for burnout. The literature suggests that people in the helping professions are at an increased risk for work-related stress and poor work life balance (Matheson & Rosen, 2012). Rosenberg and Pace (2006) assert that younger clinicians working in community agencies are especially prone to burnout. The reason is an increased caseload, inexperience, or lack of training. There needs to be more resources on preventing burnout for the novice clinician. This notion offers a conundrum, as new clinicians are often excited about entering the field but are simultaneously at high risk for burnout. Therefore, this increased risk for younger clinicians opens an opportunity for dialogue on what preventative measures can be taken.

Research suggests that due to the nature of the helping profession and the increased risk of compassion fatigue, there is no way to completely eliminate the risk of burnout (Dorociak, Rupert, Bryant, & Zahniser, 2017). However, there are some ways to help reduce the risk or to help novice clinicians

incorporate self-care into their professional lives. Researchers suggest that therapists who integrate a wellness plan into their professional lives are less likely to feel burnout (Coaston, 2017). Counselors should incorporate self-awareness into the wellness and self-care plan. This allows space for recognition and acceptance of symptoms of burnout, as well as self-compassion when these symptoms do arise (Coaston, 2017). It can be argued that self-compassion may be especially important for novice clinicians who may be more critical of their clinical skills and capabilities. Just as counselors have borrowed the concepts of positive regard and acceptance for clients, they must also allow themselves this same regard and acceptance.

Adequate supervision is another way to help decrease the risk or impact of burnout for young clinicians. Research suggests that supervision should be a forum where novice clinicians are encouraged to incorporate their own personal experiences and true authentic selves with their professional experiences. Supervision acknowledges the person of the therapist and can truly validate the therapist feeling burnout, rather than assigning pathology (Carlson & Erickson, 2001). Allowing a safe, empathetic space during weekly supervision for a discussion on self-care and wellness allows newer therapists an opportunity to truly explore and process the rewarding yet challenging aspects of the counseling profession and opens up a dialogue on the necessity for self-care.

A balance between professional and personal life is an indicator of good self-care. Imbalance has been known to be a contributing factor to burnout. It is important that clinicians are able to have balance in their lives that is uniquely tailored to fit their lifestyles (Wise, Hersh, & Gibson, 2012). Spending frequent time with family and friends, and participating in other social activities or forms of social support help maintain balance with the demands of the helping profession (Dorociak et al., 2017).

Tip Your Hat

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