Introduction

The purpose of the instructor manual for *Counseling Techniques* is to present individuals with resources for teaching a course on practical counseling techniques, as the name suggests. The manual is divided into three sections.

The first section is divided by chapter, covering each of the 28 chapters from the book. Each chapter includes key terms, key points, student learning objectives, a chapter summary, pedagogical suggestions, and a 25-question quiz. Key terms and key points provide the reader with a quick overview of the chapter. Student learning objectives delineate the general goals a student should have for mastering the information in the chapter. Chapter summaries provide a brief summary of the chapter, and pedagogical suggestions provide ideas for teaching the chapter’s material to students. Finally, the chapter quizzes consist of 25 questions in the form of fill-in-the-blanks, true/false, and multiple choice, with the answers bolded. In the volume *Counseling Techniques*, every chapter is unique in its content and length, and therefore the length for each part in this manual (key terms, points, chapter summary, etc.) varies according to the chapter it reflects.

The second section consists of both a midterm exam and a final exam. Each exam contains fifty questions taken from the chapter quizzes, with the answers bolded. Study guides for both exams are available but not physically included in this manual.

Finally, the third section contains two sample syllabi, one for a Mon/Wed/Fri course and one for a Tue/Thurs course. Each syllabus includes a short description, student learning objectives, and a sample schedule with suggested readings, assignments, and quiz/exam dates.

It has been a joy and an honor to create these resources for *Counseling Techniques*. I hope that this manual will be of help in teaching the valuable information compiled in this volume.

Chelsea M. Breiholz
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Chapter 1

Laying the Groundwork by John C. Thomas, PhD, PhD

**Key Terms:** SITs (strategies, interventions, and techniques), the technique controversy, techniques, targets, practice-based evidence, client outcome, timing, the person-of-the-counselor, schoolism, evidence-based treatment (EBT), Spirit-infused counseling

**Key Points:**
- Research has shown SITs to be highly effective, but they are not without controversy, as some prefer to focus on the counseling relationship over the SITs.
- The purpose of SITs is to address the client’s particular goals, or targets.
- Although the terms *strategies, interventions,* and *techniques* are used interchangeably, they technically have slightly different meanings, with strategies being the most broad and techniques being the most specific.
- SITs are important, but the person of the counselor is more important.
- SITs are beneficial, but the therapeutic relationship and the Holy Spirit are the gateways through which real, lasting change occurs.

**Student Learning Objectives:**
- To understand the potential arguments for and against the use of SITs
- To comprehend the purpose of SITs and to delineate the differences between the terms *strategies, interventions,* and *techniques*
- To be able to explain the value of SITs, the value of the person of the counselor, and the value of the Holy Spirit’s involvement in the counseling process

**Chapter Summary:**

The use of strategies, interventions, and techniques (SITs) in the counseling process is endorsed by the majority of counselors, according to current research; some of them are learned in graduate school and others are learned out in the field. However, research also suggests that there is still some controversy over the use of SITs, mostly on the basis of philosophical stances. Famous existential icon Irvin Yalom, for example, prefers to emphasize the personal, healing relationship with a client as the main aspect of counseling rather than SITs. Others take a stance of indifference towards SITs, wanting to merely follow whatever the current research
states as evidence-based practice. The author of this chapter, John Thomas, asserts that the therapeutic relationship is not only a SIT in and of itself, but it is also the gateway through which the use of all other SITs can be effectively employed.

The purpose of SITS are to address the myriad emotional processes and issues that are the goals, or targets, of counseling. It is important to match the appropriate SIT with the appropriate goal, just like correctly aiming an arrow at a particular target. For Christian counselors, it is important to remember the target of spiritual transformation and to be competent in various SITs related to this area. The desired outcome of therapy, determined by the client, will serve as a guidepost in helping the counselor consider which SITs would be most helpful for the client’s particular goals.

Strategies, interventions, and techniques can and usually are used interchangeably, but there are some differences among them. Strategies represent the big picture, or the overall plan to achieve a certain goal, such as motivational interviewing or self-awareness. Interventions are the specific plans to address specific aspects of the goal(s), such as assigning homework or examining a client’s beliefs. Techniques are the specific action steps taken within those interventions, such as writing down maladaptive, untrue thoughts and replacing them with healthy, true thoughts. It is important to consider the issue of timing as well, and determine which particular SITs would be most effective for each client during different times throughout the counseling process.

No discussion of SITs would be complete without discussing the person of the counselor. Competence with SITs is important, but the person of the counselor is more important, as the counselor is the gateway through which SITs enter into the counseling process. The counseling profession does attract healthy individuals, but it attracts unhealthy individuals as well, so it is crucial to pay attention to one’s own psychological health as well and face any issues of our own when we become aware of them. One’s values will come through in the counseling process both implicitly and explicitly, so remembering to emphasize working on your own person is necessary.

Although strictly adhering to particular schools of thought when it comes to counseling has mostly gone out of style, it is still wise to have a solid, theoretical base for conceptualizing the counseling process in a way that reflects one’s values. The common factors movement has resulted in taking the “common factors” among effective treatment modalities and incorporating them into practice when appropriate; this is also referred to as being “eclectic,” a word which many counselors today choose to describe their approaches. Although many techniques originated from particular schools of thoughts, they themselves have potential to be effective regardless of one’s personal theoretical inclinations. Specific multicultural considerations are not often formally addressed in this book, but it is
wise for the reader to keep them in mind when studying and employing SITs as well.

Research reveals a myriad of benefits to using SITs, but there is a limitation—by themselves, they cannot create real change. This is similar to the concept of preaching a technically well-crafted sermon that has no impact on the audience. Between the action and the impact are the person of the counselor and the person of the client, and for the Christian, also the Holy Spirit. SITs are empty without the power of the therapeutic relationship and the power of the Holy Spirit. The Holy Spirit works supernaturally in us, our clients, and in the counseling process itself, and this sets Christian counseling apart. These elements all serve as the foundation on which the use of the SITs is built.

There are six recommended guidelines to follow when considering the use of SITs. As a Christian counselor, one must always evaluate them in light of a Christian worldview and in light of truth to determine whether they are appropriate, using both the Bible and current research. For example, mindfulness is sometimes a controversial SIT, with some associating it with Buddhism only, and others recognizing it as perfectly compatible with Christianity. One must also determine if SITs are compatible with one’s own values; if they are not, they will not be authentic and should not be used. It is also necessary to determine if SITs align with your own theoretical views of counseling and conceptualizing human functioning. One should always prioritize the well-being of the client, and make sure the SIT is appropriate for the particular issue(s) being addressed. Finally, it is wise to be flexible in one’s approach and to always explain the rationale behind SITs to your clients, similar to the process of explaining informed consent.

In conclusion, although the different ways of viewing and employing SITs may not always be shared by every counselor or researcher, research shows that SITs are incredibly helpful and effective. Yet it is important to remember that SITs are only tools, and the person of the counselor (and the Holy Spirit) is the gateway through which they can create lasting change in the lives of clients.

**Pedagogical Suggestions**

- Have students either as a whole class or in groups discuss the pros and cons of using techniques in therapy.
- Ask students to discuss or write about the differences between strategies, interventions, and techniques as discussed in the book and to create their own examples of each one.
- Ask students to discuss or write about ways in which their values, or a counselor’s values, could be implicitly or explicitly expressed in the
counseling process; ask them to give specific, detailed examples to the best of their abilities.

- Ask students which benefits of using SITs stand out to them the most (see p. 21 for a list of benefits and rationales) and why they view them as the most important. Ask if they can think of any other possible benefits not listed in the text.
- On page 23, the author states, “Knowing a Bible verse and having it well formed in your mind and heart are quite different.” Have students discuss or write about how these two things are different and to give specific examples from their own lives.
- Discuss as a class if anyone feels there are any techniques not consistent with Christian values and why.
- Have students discuss or write about the differences between Buddhist mindfulness and Christian mindfulness, using their own current knowledge and the information from the text on pages 23-24.

Chapter 1 Quiz (25 questions)

Fill in the blank

1. In opposition to the use of SITs, existentially-minded ____________________
   “asserts that counseling is a relationally driven enterprise rather than theory or technique driven” (p.15). (Yalom)
2. __________________ are the big picture, the “modus operandi,” or plans of action customized to meet a particular goal. (strategies)
3. __________________ are the specifics of the plans used to address a particular goal. (interventions)
4. __________________ are the particular action steps used in working towards a particular goal. (techniques)
5. Therapeutic skill is important, but __________________ subsumes any ability, theory, or technique. (the person-of-the-therapist)
6. __________________ is the idea that one theoretical system is correct and all other systems are incorrect, inferior, and/or irrelevant. (schoolism)
7. __________________ looks at various components involved in all or most of the effective treatments and incorporates these into the treatment packages. (the common factors movement)
8. When mindfulness is conceptualized from its roots in __________________, it involves an emptying of the mind, which is different from Christian mindfulness. (Buddhism)
9. ________________ involves knowing what you want to do or need to do, so that you can have a clearer sense of how the session should proceed and how to accomplish what is necessary to bring change. (counselor intentionality)

10. The intended audience of this book is _______________. (graduate students and/or counselors)

**True or False**

1. The therapeutic relationship itself is not considered a SIT. (T/F)
2. The measuring stick for counseling efficacy is client outcome, which is defined ultimately by the counselor. (T/F)
3. A prerequisite of an effective intervention or technique is timing. (T/F)
4. The person of the counselor is the instrument and the tool by which therapy happens. (T/F)
5. “Eclectic” is typically code for borrowing SITs from many schools of psychotherapy. (T/F)
6. Techniques cannot be used appropriately and effectively unless they are used within exclusive schools of psychotherapy only. (T/F)
7. Counseling is best defined as a collection of techniques. (T/F)
8. The collection of SITs in this book are meant to be a “cookbook” approach to clinical work. (T/F)
9. Christian mindfulness is about maintaining a nonjudgmental and present acceptance of awareness based on divine grace. (T/F)
10. Any SIT that makes you feel uncomfortable or is discordant with your person should still be at least attempted if you feel it would be helpful. (T/F)
11. Each chapter of this book will include: a theology and psychology of the topic; at least one case study, and then exemplary strategies, interventions, and techniques. (T/F)
12. Counseling is an interpersonal process, meaning that it is the passive involvement of two or more participants. (T/F)
13. The poem at the end of this chapter was written by St. Andrews. (T/F)

**Multiple Choice**

1. The analogy for SITs and goals used in the text involved using ________________ to hit targets
   a. Balls
   b. Darts
   c. Knives
   d. Arrows
2. Guidelines for using SITs, as discussed in the text, include all but ONE of the following:
   a) Ensuring that the SITs are consistent with you, the therapist
   b) Determining if the SITs are consistent with a Christian worldview
   c) **Ensuring you have at least three Bible verses that support the SIT you are planning to use**
   d) Considering the welfare of your client
Chapter 2
Evidence-Based Counseling by David Lawson, PsyD

Key Terms: EBT (evidence-based therapies), confirmation/selection bias, health-management organizations (HMOs), Sigmund Freud, Hans Eysenck, Sackett, eclecticism, diagnostic ability, self-care, Jeffrey Kottler, cognitive behavioral therapy (CBT)

Key Points:
- Although for some EBTs have a poor reputation, research has shown they are highly effective and necessary for the welfare of clients and the validation of the counseling field.
- The genesis of the EBT movement is attributed to Freud, as he modeled his own theory of psychotherapy after the medical model of his time.
- A research study by Eysenck, a 1960s researcher, was cited for many years as evidence that therapy was ineffective, although this research has since been discredited.
- EBTs are beneficial for the counseling field, as they help ensure the best client welfare and allow the clinicians to create more effective treatment plans due to the emphasis on accurate diagnosis.
- Lack of prevention, such as self-care, and inconsistency among therapists are two problems that the EBT movement hopes to address in the future.
- However, EBT is not without its challenges in the research world, including issues with validity, the use of secondary data, and regression towards the mean.
- Evidence-based techniques and evidence-based therapists are two other EBT movements worth paying attention to in the research.

Student Learning Objectives:
- To understand the reasons EBTs have a poor reputation and why they are often poorly understood
- To be able to explain the origins of the EBT movement and the key researchers/therapists involved
- To comprehend the benefits and value of EBTs
• To be able to list and explain the problems the EBT movement hopes to address in the future and the three current challenges EBT faces in the research world
• To develop a basic understanding of the other two EBT ideas mentioned in this chapter, evidence-based techniques and evidence-based therapists

Chapter Summary:

The topic of evidence-based therapies (EBTs) is often viewed by both authors and readers alike as unnecessary and uninteresting, in comparison to other counseling-related topics; EBTs can have a reputation among graduate students and young counselors as being “all about the money” and “heartless” due to their association with insurance companies and limiting session numbers for clients. Additionally, most counseling graduate programs provide poor research training, leaving students unable to fully understand EBTs. Students are typically taught to criticize research without looking for the strengths, and hence are primed to have a rather negative, skeptical attitude towards it. However, there are actually many benefits to EBTs and being able to study and understand them; these benefits will be delineated and explored in this chapter, along with possible limitations.

The creation of the first EBT is attributed to Freud, simply because he worked to make his model of therapy resemble the medical model that was subscribed to by researchers during his time. EBTs are the way in which we are able to study the field of counseling, and Freud’s contribution to their beginning must be acknowledged, regardless of one’s feelings about his actual work. EBTs also serve as evidence to defend the counseling field against those who claim it is ineffective. One of the most famous examples is that of Hans Eysenck, a psychological researcher in the 1960s who claimed that therapy did not work. He said this based on a study he conducted where people who went to therapy were compared to people who did not. The results of his study suggested that people who went to therapy did not improve more than the control group and actually even became worse. Today his research and methodologies have completely been discredited, but his work was still referenced for many years as “evidence” that therapy did not work.

Today, EBTs are beneficial for the field of counseling as well as for insurance companies because they provide evidence for what is actually effective in therapy. The medical world is based on EBTs as well, and this helps us avoid reliance on tradition and word-of-mouth, one of the problems that attempts to discredit our fields. When using EBTs in order to avoid this problem, Sackett and colleagues (1996) recommend following three guidelines in the process of therapy: developing your own clinical expertise, examining the evidence by reading current
research journals, and remembering that every client and situation are going to be different and in need of unique relational approaches. Possibly the most important benefit, however, is that clients will receive better care through the use of EBTs. EBTs help counselors to focus more on theoretical frameworks behind different treatments, and aid in the development of more effective treatment plans due to greater focus on diagnostics. Furthermore, EBTs can help counselors and clients to remain within the boundaries of the therapy and not develop unhealthy or inappropriate relationships.

Students leaving graduate school often face obstacles to pursuing knowledge of EBTs, such as being in debt, exhausted by reading, and state licensing requirements for continuing education. However, proponents of EBTs hope that instilling students with a hunger for knowledge and effective practice will help motivate them to continue examining current research in the field. Emphasizing the great need for prevention and the need for self-care, both in the medical world and the psychological world, is also a way to help students recognize the importance of understanding EBTs. There is much data on self-care, but it is rarely employed in real life, and it is hoped that as EBTs continue to grow, more individuals will utilize this important data. Yet another hope of EBT proponents is that EBTs will help reduce the great amount of inconsistency that seems to be found in the counseling world. This improvement in consistency could help counselors to avoid using SITs that have no research support and may harm their clients, as in the case of the rebirthing technique debacle where a client actually died.

Despite all the benefits previously described, David Lawson acknowledges that the EBT world has its challenges. The first challenge is that therapy is still primarily a relational experience, and thus forcing something so human and dynamic into a research study is difficult; to use research terms, there are challenges to internal and external validity. One cannot always be one-hundred-percent sure that what is seen in research will actually translate to real life therapy. The second challenge is that the counseling field uses secondary data rather than primary data. This means that outcomes cannot be measured as objectively as measuring the amount of a bacteria in the medical field. Most outcomes are measured through questionnaires, and although consumer-response questionnaires are helpful and do usually show that therapy is effective, those measures don’t exactly tell us how, objectively, the therapy was effective. Finally, regression to the mean is another challenge to EBTs. This concept simply means that over time and repeated testing, numbers tend to gather towards a center point called the mean. Mean regression interferes with statistical interpretation of study results, thus making it even more difficult for us to know if the results are objectively, certainly accurate in and of themselves.
Concerning the current state of EBT research, there are two issues that are worth noticing: evidence-based techniques and evidence-based therapists. The idea of evidence-based techniques is that with any certain type of therapy there are specific techniques that are more effective than others. However, it can be argued that this idea ignores the relational aspect of counseling and its impact on client change. The idea of evidence-based therapists, a term coined by author David Lawson himself, is that techniques alone are not enough, and different therapists can have different results even if using the same technique for the same issue.

In conclusion, despite their reputation, EBTs are highly beneficial, and their proponents are hopeful that they will continue to inspire students and counselors to increase their research knowledge, consider prevention and self-care, and improve counseling consistency in the field. Although there are challenges of validity, data, mean regression, and personal opinions, EBTs have ultimately been shown to be effective, and we should continue to immerse ourselves in research with an attitude of curiosity and wonder.

**Pedagogical Suggestions:**

- As a class or in groups, have students discuss the reasons people are usually reluctant to learn about or appreciate EBTs as stated in the beginning of the text; ask if they relate to any of these reasons and if they have any preconceived ideas or expectations about EBTs themselves.
- Using the text or even other resources as well, have students discuss or write about all the possible pros and cons of EBTs and to make a text-supported or research-supported argument for the side they lean towards most.
- On page 34, the text reads, “One of the great difficulties confronted in medicine and even in the mental health community is the common reliance on lore and tradition over evidence from our field.” Ask students to discuss or write about any examples of this they have seen or experienced.
- Have students share with the class any personal examples of self-care and how they have benefitted from it, either medically or psychologically. Also ask if they have seen or experienced any examples of “self-care” that actually did more harm than good (ex., Netflix binging) or ask if anyone would like to make an argument for the benefits of these behaviors instead.
- Ask students as a class or in groups to give examples of confirmation/selection bias from their own lives, things they have witnessed or experienced, or even make up examples to illustrate this concept.
- Ask students to list multiple examples of primary and secondary data, and ask if they have any ideas on how to help the counseling research field with its secondary data problem.
• Have students write about or discuss the three challenges to EBTs listed in the text and their views on each one, using the text to support their opinions.

Chapter 2 Quiz (25 questions)

Fill in the blank
1. Typical graduate research classes in counseling programs emphasize criticizing the ______________ and downplaying the strengths of research studies. (weaknesses)

2. One of the great difficulties confronted in medicine and even in the mental health community is the common reliance on ___________ and __________ over evidence from our field. (tradition, lore)

3. One of the benefits of EBT is the way in which it emphasizes ______________, which is the key to developing an effective plan and an effective technique. (diagnosis or diagnostic ability)

4. A benefit of prescribing EBTs is the movement away from ___________ and towards a more cogent theoretical framework. (eclecticism)

5. The ______________ technique is listed in the text as an example of a treatment unsupported by research that has therefore resulted in the death of a client, illustrating the importance of EBTs and research-supported therapy. (rebirthing)

6. ______________ bias is the idea that we are all likely to see the world from our own framework and deny or attack any other model that challenges its ideas. (confirmation and selection)

7. This form of EBT, ________________, highlights the fact that often effective therapies have specific techniques that are more effective than other techniques within the modality. (evidence-based techniques)

8. This form of EBT, ________________, a term coined by ______________, emphasizes the idea of the evidence-based therapist, as therapists using the same technique for the same issue can produce completely different results. (evidence-based therapists, Lawson)

True/False
1. EBTs give insight into what therapeutic modalities work, but they don’t provide any guidance for use of what techniques might work with specific populations. (T/F)

2. Sackett and colleagues define EBTs as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of the individual patient. (T/F)
3. The greatest benefit within the EBT framework is the greater care provided to clients. (T/F)
4. EBTs create very little emphasis on diagnosis. (T/F)
5. One of the easiest, least concerning parts of therapy is preventing the development of unhealthy relationships with clients and/or their unhealthy dependence on the therapist. (T/F)
6. Although great volumes of data exist on self-care, the vast majority of Americans rarely utilize it. (T/F)
7. The text lists binging on Netflix as a beneficial example of self-care. (T/F)
8. One challenge to EBTs is that the counseling field measures outcomes using secondary data rather than primary data. (T/F)
9. Psychoanalytical studies are listed in the text as an example of why regression towards the mean is a challenge for EBTs. (T/F)
10. EBT, while useful, is not the best way for therapists to research what works in therapy and what does not. (T/F)
11. One limitation of EBT is that it negatively impacts psychotherapy’s challenge of inconsistency and the often extreme variance found between therapists. (T/F)
12. Internal validity and external validity are research challenges associated with EBTs. (T/F)

Multiple Choice
1. According to the text, people are reluctant to read about or advocate for EBTs because:
   a) EBT study can feel unnecessary to those who work in such a relational field.
   b) EBTs sometimes have a bad reputation for “being all about money.”
   c) Poor training in understanding research
   d) Poor training in counseling
   e) A, B, and C
2. The individual said to have initiated the EBT movement was:
   a) Eysenck
   b) **Freud**
   c) Nietzsche
   d) Sackett
3. This individual’s work, although currently discredited, was used for many years to support the claim that therapy was ineffective:
   a) Freud
   b) **Eysenck**
   c) Kotler
d) Rosenberg

4. Which of the following is NOT one of Sackett’s three key components of the decision process for therapy with clients?
   a) Clinicians must evaluate what evidence is available in best practice and treatments.
   b) Clinicians must know that the clinical expertise of the clinician is key.
   c) Clinicians must remember that every client is unique and requires a uniquely different way of engagement.
   d) **Clinicians must remember the importance of subscribing to current research journals in the field.**

5. Which of the following, if any, is NOT one of the challenges to EBT proposed in the text by Lawson?
   a) The active, dynamic process of therapy cannot be forced into a research study.
   b) In EBT research, we do not see or evaluate primary data.
   c) Scores on outcome measures tend to regress towards the mean over time.
   d) **Tradition and lore are still effective in both the medical and psychological fields, and therefore create doubt over the necessity of EBTs.**
Chapter 3
*Cognitive-Based Strategies* by Gary Sibcy, PhD, & John C. Thomas, PhD, PhD

**Key Terms:** cognitions, cognitive behavioral therapy (CBT), schema, cognitive rule, discovery, deconstruction/deactivation, development, socratic questioning, goal setting, daily mood log, subjective units of distress (SUD) scale, magic button technique, cognitive restructuring, discrimination training, downward arrow/vertical arrow technique, experimental technique, cognitive-behavioral analysis system of psychotherapy (CBASP), situational analysis (SA), Sibcy river technique, the slice of time technique, the cost-benefit technique, externalization of voices technique, problem-solving technique, survey technique, the reattribution technique, the defining terms technique, the semantic method technique, the role reversal technique

**Key Points:**
- Research has demonstrated that Cognitive Behavioral Therapy (CBT), based on the philosophy that all problems are rooted in maladaptive cognitions, is positively correlated with client outcomes, and many of the SITs utilized in CBT have been shown to be highly effective.
- The psychology behind CBT is the idea that we all view the world through filters called schemas, developed mostly through our early life experiences. Cognitive rules, which utilize compensatory strategies, are the rules we make up to protect our schemas from being triggered.
- This therapy fits very well with a Christian worldview, and the use of Scripture as a basis for objective truth allows for a unique and deeper impact.
- Cognitive SITs can be split into two main groups: traditional and third-wave. The traditional group consists of the first two waves of cognitive therapy. The first wave focuses mostly on behavior and the second wave focuses on disputing cognitive distortions.
- The third wave of cognitive therapy focuses not on the content of a client’s thoughts but how the client relates to his or her thinking, or the process. This wave mainly consists of three methods, or stages: discovery, deconstruction/deactivation, and development.
- Discovery is similar to assessment, and simply involves assessing the cognitions of the client, particularly the maladaptive ones. Example
techniques include inventories, socratic questioning, goal setting, daily mood logs, agenda setting, and the magic button technique.

- Cognitive restructuring is a common technique that can be used for all three D stages; it helps clients to identify maladaptive cognitions, examine their validity, and replace them with adaptive ones.
- Another type of cognitive restructuring is known as cognitive behavioral analysis system of psychotherapy (CBASP), which analyzes triggering client situations in a detailed manner.
- Deconstruction and deactivation techniques are aimed at helping to weaken the client’s faulty or unhelpful cognitions.
- After faulty cognitions have been discovered and deactivated, they must be replaced by developing healthy and truth-based cognitions.

**Student Learning Objectives:**

- To understand the psychology and theology behind CBT
- To be able to describe the differences between traditional and third-wave CBT and the main people associated with them
- To comprehend the three different stages/methods of third-wave CBT and gain a basic understanding of the variety of SITs associated with them
- To be able to explain the processes of cognitive restructuring and the therapy of CBASP

**Chapter Summary:**

Cognition is a very broad term, referring generally to all the phenomena that happen inside the mind. Research has demonstrated that Cognitive Behavioral Therapy (CBT), based on the philosophy that all problems are rooted in maladaptive cognitions, is positively correlated with client outcomes, and many of the SITs utilized in CBT have been shown to be highly effective.

To understand the basics of CBT, it is important to consider both the psychology and theology behind it. CBT holds to the assumption that all cognitions are filtered; that is, rather than seeing the world the way it objectively is, we see the world the way we are. We all interpret and experience the environment in different ways. Clinically, this is known as having schemas. Schemas are core beliefs learned through life experiences, particularly experiences during an individual’s early life. Schemas are responsible for how we remember, how we pay attention, and how we translate our experiences. The text cites the work of Young (1998) who has created a list of eighteen basic schemas, a list commonly used as a reference today. Although not exhaustive, the list includes schemas such as emotional deprivation, self-sacrifice, abandonment/instability,
defectiveness/shame, and dependence/incompetence. Schemas generate associated emotions and beliefs, such as “I am undeserving of respect.” Schemas also generate cognitive rules, which usually go to the opposite extreme of the schema in an attempt to protect the schema from being activated—for example, “I will present myself in ways to get respect from others.” Cognitive rules then generate compensatory strategies, which are the specific coping mechanisms one uses to support the cognitive rule and ultimately the schema. In addition to the psychology it is also important, as Christian counselors, to consider the theology behind CBT. This therapy fits very well with a Christian worldview, and the use of Scripture as a basis for objective truth allows for a unique and deeper impact. Scripture reveals that our cognitions are tainted by sin from the Fall, but also that our cognitions can be redeemed, beginning at salvation and continuing on in the process of sanctification.

Cognitive SITs can be split into two main groups: traditional and third-wave. The traditional group consists of the first two waves of cognitive therapy. The first wave focuses mostly on behavior and the second wave focuses on disputing cognitive distortions. The second wave is exemplified in two different ways in the works of Ellis and Beck, two therapists who worked in the 1970s; Ellis emphasized logic and examining maladaptive thoughts such as “should be” and “must be,” while Beck highlighted cognitive distortions and correcting them. The third wave of cognitive therapy focuses not on the content of a client’s thoughts but how the client relates to his or her thinking, or the process. This wave mainly consists of three methods, or stages: discovery, deconstruction/deactivation, and development.

Discovery is similar to assessment, and simply involves assessing the cognitions of the client, particularly the maladaptive ones. Example techniques include inventories, socratic questioning, goal setting, and daily mood logs, which ask the client to record distressful events, rate their distress on a subjective units (feelings) of distress (SUD) scale, and examine the thoughts behind their feelings. Another discovery technique is agenda setting, which can actually be used in all three D stages. The text discusses the ISTOP acrostic proposed by Burns to delineate the steps: 1) invitation, which invites the client to make a change 2) specificity, asking the client to be specific 3) troubleshooting, examining the problem itself, and 4) openness, which examines the degree to which the client wants to change. In regards to openness, there are two different types of resistance: process resistance and outcome resistance. In process resistance, the client simply doesn’t want to do the work a specific change requires. In outcome resistance, the client does not want to face the consequences that changing the behavior or cognition might create. Finally, the P in ISTOP refers to Plan, which involves conceptualizing the problem into one of four categories: mood/anxiety, unwanted
habit or addiction, relationship problem, or no problem. After the problem is conceptualized, the appropriate treatment plan and SITs can be considered.

Yet another discovery SIT is the magic button technique, also known as the paradoxical cost-benefit analysis, which is a helpful way to address resistance. This technique involves having clients imagine there is a magic button that would make their problem disappear, and asking if they would press that button. Usually the client will say yes, and so the counselor can then ask them to consider if there are any disadvantages to pressing the button. According to the text, 90 percent of the time clients say there are no disadvantages, and the counselor can gently make suggestions.

Cognitive restructuring is a common technique that can be used for all three D stages; it helps clients to identify maladaptive cognitions, examine their validity, and replace them with adaptive ones. The technique begins with educating clients about the nature of cognitions, schemas, and CBT, as described in the beginning of this chapter. The counselor can use a cognitive distortion checklist to then help the client examine his or her cognitions, and can also use Scripture as a basis for truth. Through this process, the counselor can assist the client in identifying faulty cognitions on their own, also known as discrimination training. The downward arrow/vertical arrow technique and the experimental technique are two ways of helping the client learn how to do this.

The downward arrow technique involves asking the client to temporarily assume a particular cognition is true, and to ask a series of “if…then” questions, such as “If ______ is true, what does that mean?” Judith Beck emphasizes that asking what the thought means about the client rather than to the client will ultimately lead to the underlying schema. The experimental technique involves asking the client to conduct an experiment to examine the validity of a particular cognition. If the client does find that a cognition is not true, it is then replaced with a thought that is based on truth, and the counselor must help the client to turn the new thought into an internalized habit through repetition and practice.

Another type of cognitive restructuring is known as cognitive behavioral analysis system of psychotherapy (CBASP), which analyzes triggering client situations in a detailed manner. Based on contemporary learning theory, CBASP has been shown to be highly effective with mood problems and is the only current EBT for chronic depression. Situational analysis (SA) is a helpful CBASP technique in which clients examine their roles in relationships and determine if their thoughts in a particular situation were helpful or unhelpful.

Deconstruction and deactivation techniques are aimed at helping to weaken the client’s faulty or unhelpful cognitions. In the double-standard technique, the counselor asks the client what they would say to someone they love who was in the same situation they are. In the Sibcy river technique, clients learn that just because
they have a thought doesn’t mean that it’s true or that they even believe it. Clients learn to visualize their thoughts, feelings, images, and sensations (TFIS) as floating down a river while they stand on the bank and observe them. The slice of time technique involves looking at a particular time/situation and examining the client’s narrative during that time. The cost-benefit technique is self-explanatory and involves examining the costs and benefits of a belief or thought. Other helpful techniques include the survey technique, the reattribution technique, the defining terms technique, the semantic method technique, and the role reversal technique, which are explained in more detail in the text.

After faulty cognitions have been discovered and deactivated, they must be replaced by developing healthy and truth-based cognitions. This process involves problem solving. One example is the externalization of voices technique, where you and the client take turns role-playing the dysfunctional thoughts. Another example is a basic problem-solving technique in which the problem is identified clearly, previous attempts to solve the problem are examined, a list of all possible solutions are made and investigated, and a solution is ultimately chosen by the client.

This chapter discussed a myriad of techniques that fall under the broad spectrum of cognitive-behavioral therapy (CBT), typically seen as being divided into three stages or methods of discovery, deactivation, and development, although techniques can overlap among them. What all these techniques have in common is that they belong to a methodology that has been shown to be evidence-based and highly valuable in the counseling field; as Christians, it is especially important to identify these unhealthy or untrue thoughts and replace them with the truth, especially truth found in Scripture, as this is part of our lifelong process of sanctification.

**Pedagogical Suggestions:**

- To illustrate the concept of schemas, provide the list of 18 schemas given by Young in the text (pp. 45-46) and ask students to come up with a related emotional statement (“showing sadness is a sign of weakness”) cognitive rule (“I will present myself in ways to get respect from others”) and compensatory strategies (“don’t reveal any vulnerable information that might cause someone to disrespect you”) for each schema. Assign each student a group of schemas to write about, or have the students break into groups for discussion and assign a set of schemas to each group.

- Have students visit the website www.schematherapy.com and become familiar with it. Free sample schema inventories are available, and students may practice taking them if desired.
• Ask students to write about or discuss the similarities and differences between Christian CBT and “secular” CBT, using information from the text, other sources, the Bible, and life experiences, both real and/or hypothetical.
• Have each student, using the text, create a flow chart illustrating all the different categorizations and techniques discussed in the chapter and how they relate to each other. Encourage them to personalize it however their brain understands the information best and to use colors or pictures or whatever system they would like to illustrate CBT.
• Break students into pairs, and have students pick three techniques from the chapter. Then each student will explain those three chosen techniques to their partner, using as much detail as possible, as if their partner were a client who had no prior knowledge of the techniques.
• Choose an imaginary faulty cognition such as “I am worthless because I got a low grade on my exam at school” and have the class brainstorm and explain different ways to address that cognition, using any technique or combination of techniques from the text.

Chapter 3 Quiz (25 Questions):

Fill in the blank

1. ________ is a strategy for recognizing automatic thoughts, improving problem solving, and developing emotional regulation skills. (Daily mood log)
2. The ________________ technique involves asking the client to assume a cognition is true and to then ask a series of “if….then” questions to ultimately uncover an underlying core belief or schema. (downward arrow/vertical arrow)
3. ________________ is recognized as the only evidence-based treatment for chronic depression and is highly useful in helping clients walk through many mood issues. (CBASP)
4. In the __________ technique, the therapist asks the client if or she would use the same negative, perfectionistic, black-and-white patterns of thinking to relate to a dear friend, e.g. “What would you say to a friend who is in the exact same situation as you?” (double-standard technique)
5. The __________ technique is a role-play exercise whereby you verbalize the client’s dysfunctional thoughts as accurately as possible while the client attempts to counter your verbalizations with healthier and more adaptive responses. (externalization of voices)
True/False

1. Maladaptive patterns of thinking are considered to be the root of all problems, according to CBT. (T/F)
2. A.T. Beck’s approach to CT emphasized the functionality of thoughts, and he was famous for creating the river metaphor. (T/F)
3. Ellis’s approach to CT was largely philosophical and examined client logic, including maladaptive thoughts such as “I must be ______ in order to be happy.” (T/F)
4. The third wave of CT is less concerned about the content of how a client thinks and instead focuses on the relationship the client has with his or her thinking. (T/F)
5. The river metaphor teaches clients to observe thoughts, feelings, images, and sensations and then attach themselves to these experiences. (T/F)
6. Discovery involves activities aimed at gathering cognitive data from clients. (T/F)
7. The first step in a daily mood log requires that the client describe a distressful event in detail and then record the negative affect associated with the event using the SVU scale. (T/F)
8. The second step in a daily mood log is for clients to explore the negative thoughts associated with the identified afflicted feelings. (T/F)
9. The magic button technique is also known as paradoxical cost-benefit analysis. (T/F)
10. Cognitive restructuring is a technique that should only be used in the Development phase. (T/F)

Multiple Choice:

1. Which of the following are examples of cognitions, according to the text?
   a) Attention
   b) Beliefs
   c) Expectations
   d) Categorization of stimuli
   e) All of the above
   f) Only A and D
2. Techniques aimed at cognitions are directed primarily at which of the following?
   a) Building cognitive regulation skills
   b) Correcting biases, errors, and distortions in information processing
   c) Modifying problematic core beliefs and schemata
3. The main methods of third-wave cognitive therapy include all of the following except:
   a) Deconstruction/deactivation
   b) Dissemination
   c) Discovery
   d) Development
   e) None of the above

4. Examples of discovery SITs include:
   a) Goal setting
   b) Inventories
   c) Socratic questioning
   d) Daily mood log
   e) All of the above
   f) Only A and D

5. The text uses the following acrostic to explain agenda setting:
   a) ICANT
   b) ISTART
   c) ISTOP
   d) IKNOW
   e) IPHONE

6. Openness refers to a client’s willingness to address a problem. Which of the following are types of resistance a client can have?
   a) Outcome resistance
   b) Consequence resistance
   c) Process Resistance
   d) A and C
   e) B and C
   f) None of the above

7. During the planning stage, a problem can be conceptualized as fitting into one of four categories. Which of the following is NOT one of those categories?
   a) An unwanted habit or addiction
   b) A relationship problem
   c) No problem
   d) A first-world problem
   e) A mood or anxiety problem

8. ____________ distinguishes between asking what the thought means to the client, which elicits an intermediate belief, and asking what it means about the client, which usually uncovers the core belief.
a) A.T. Beck  
**b) Judith Beck**  
c) Burns  
d) Leahy  
e) None of the above
**Chapter 4**  
*Emotion-oriented Strategies* by Todd Bowman, PhD

**Key Terms:** emotion, attachment, still-face experiment, relational soothing, primary and secondary emotions, emotional awareness, attention to emotion, emotional clarity, shame, guilt, connect and redirect, name it to tame it, SIFT, specificity, sensitivity, empathy

**Key Points:**
- Bowman posits that our relationships with God and with our human primary attachment figures determine our abilities to journey through our emotional worlds.
- The “still face experiment” by Ed Tronick in the 1970s illustrates how a primary attachment figure’s engagement affects an infant’s emotions. In this experiment, the mother emotionally engages with the infant through relational synchrony and then later becomes unresponsive, causing the infant to scream in distress and eventually turn away in shame.
- Unhealthy behaviors, such as addictions and other harmful coping mechanisms, emerge as individuals grow older and seek ways to assuage distressful emotions that are too overwhelming for them to regulate on their own; these behaviors are attempts at self-soothing, and they are aimed at disconnecting people from the emotional experiences that feel too intense for them to bear.
- Behaviors with “high primitiveness and high potential for novelty” (Bowman, 2018) are prioritized by the brain, and hence the popularity and highly addictive quality of sex, food, drugs, and media.
- However, human connection is still the most powerful form of emotion regulation.
- Plutchik divides emotions into two categories of primary and secondary.
- Primary emotions are joy/sorrow, anger/fear, acceptance/disgust, and surprise/expectancy, and sit on a spectrum that ranges in intensity. Secondary emotions are combinations of primary emotions with other emotions, and consist of love, submission, awe, disapproval, remorse, contempt, aggressiveness, and optimism.
- The two aspects of emotional awareness are attention to emotion and emotional clarity.
- Guilt refers mainly to remorse over one’s actions whereas shame refers to a feeling that the self itself is defective and worthless.
- Another model of conceptualizing emotion is proposed by Jaak Panksepp, who describes seven systems of neural circuitry: seeking, fear, rage, lust, care, panic (separation distress), and play.
- Connect and Redirect is a part of Siegel and Payne Bryson’s model of emotions; it is the idea that human connection, particularly in right-brain, nonverbal ways such as facial expressions and touch, helps individuals to “feel felt” and tune into their own emotional experiences.
- Another intervention by Siegel and Payne Bryson is called Name It to Tame It, which is somewhat self-explanatory and involves using story to process one’s emotions.
- The SIFT—sensations, images, feelings, and thoughts—model by Siegel is a method of examining bodily sensations to help one identify one’s emotions more accurately.

**Student Learning Objectives:**

- To understand attachment, the still-face experiment, the reasons for turning to unhealthy behaviors and the power of human connection in emotion regulation
- To be able to describe the emotional processing models (and associated terms and SITs) of Plutchik, Panksepp, and Siegel and Payne Bryson
- To comprehend the differences between Shame and Guilt and provide biblical examples

**Chapter Summary:**

Emotion comes from a Latin word meaning “to move” and is part of our *Imago Dei*. In an attempt to examine the psychology and theology of emotion, one must address the idea of attachment. In the beginning, God declared that it was “not good for the man to be alone” (Genesis 2:18). God also is the ultimate secure attachment relationship, as he reveals through his relationship with the Israelites throughout the Old Testament. Bowman posits that our relationships with God and with our human primary attachment figures determine our abilities to journey through our emotional worlds.

The “still face experiment” by Ed Tronick in the 1970s illustrates how a primary attachment figure’s engagement affects an infant’s emotions. In this experiment, the mother emotionally engages with the infant through relational synchrony involving eye-contact, prosody of speech, and exploring the environment together. After this engagement, the mother “stills” her face and
becomes emotionally and physically unresponsive to the infant. At first the infant is immediately distressed and makes repeated attempts to communicate and get the mother’s attention. When the mother remains unresponsive, the infant’s cries of distress escalate, until finally he turns away and hides his face, a physical gesture embodying the emotion of shame. This response shows how shame, an emotion of feeling deficient and defective, is from the beginning rooted in feeling psychologically and emotionally cut-off from one’s primary attachment figure.

Unhealthy behaviors, such as addictions and other harmful coping mechanisms, emerge as individuals grow older and seek ways to assuage distressful emotions that are too overwhelming for them to regulate on their own; these behaviors are attempts at self-soothing, and they are aimed at disconnecting people from the emotional experiences that feel too intense for them to bear. Behaviors with “high primitiveness and high potential for novelty” (Bowman, 2018) are prioritized by the brain, and hence the popularity and highly addictive quality of sex, food, drugs, and media. However, human connection is still the most powerful form of emotion regulation. Bowman provides the example of Jesus on the cross telling his mother and his disciple John to turn to each other in John 19:26-27 to illustrate this concept of turning to another person when facing difficult emotions. When we do this, we engage in a process known as relational soothing, “in which shame is replaced with acceptance, fear is exchanged for a deep sense of safety, sadness is lifted through the gift of presence, and pain is soothed away by the outstretched arms of comfort” (Bowman, 2018). In the counseling office, we as therapists have the opportunity to provide this experience to our clients.

Once attachment is understood, it is important to find a definition of emotion. Referring back to its Latin roots, Bowman (2018) offers the following: “[emotion is] the psychological experience of being moved by a feeling toward something the individual deems important” (p. 74). Bowman refers to Plutchik’s 1958 model as a way of conceptualizing emotion; Plutchik divides emotions into two categories of primary and secondary. Primary emotions are joy/sorrow, anger/fear, acceptance/disgust, and surprise/expectancy, and sit on a spectrum that ranges in intensity. Secondary emotions are combinations of primary emotions with other emotions, and consist of love, submission, awe, disapproval, remorse, contempt, aggressiveness, and optimism. In order to regulate emotions effectively, one must be aware of and be able to accurately identify the emotion, as well as feel the emotion to the appropriate degree of intensity. The two aspects of emotional awareness are attention to emotion and emotional clarity.

However, the emotion of shame is missing from Plutchik’s list, and Bowman postulates that shame should be considered a primary emotion, and that it is the opposite of attachment, highlighting the social nature of it. He also
differentiates shame from guilt, stating that guilt refers mainly to remorse over one’s actions whereas shame refers to a feeling that the self itself is defective and worthless. He illustrates this concept biblically with two stories: the story of Adam and Eve eating the forbidden fruit in Genesis 3 and the story of Nathan using a hypothetical story to confront David’s murder of Uriah in 2 Samuel.

Another model of conceptualizing emotion is proposed by Jaak Panksepp, who describes seven systems of neural circuitry: seeking, fear, rage, lust, care, panic (separation distress), and play. These are primitive emotions located near the bottom of the brain in the limbic system and brainstem, similar to other instinctual survival behaviors such as eating, implying they are perhaps of similar importance.

Concerning SITs that are helpful when working with emotions, a book by Siegel and Payne Bryson entitled *The Whole-Brain Child* suggests a SIT called Connect and Redirect, where Redirect refers broadly to client outcome. This is simply the idea that human connection, particularly in right-brain, nonverbal ways such as facial expressions and touch, helps individuals to “feel felt” and tune into their own emotional experiences. Another intervention is called Name It to Tame It, which is somewhat self-explanatory and involves using story to process one’s emotions. This is simply where the client tells the story of his or her experiences and externally processes with the counselor.

Finally, the SIFT—sensations, images, feelings, and thoughts—model by Siegel is a method of examining bodily sensations to help one identify one’s emotions more accurately. This is especially helpful when clients have difficulty with emotional awareness, specificity, and sensitivity. Learning to tune into their own emotional experience will help clients to increase their ability to empathize.

**Pedagogical Suggestions:**

- Have students write about or discuss biblical examples of attachment as discussed in the text and how these examples build a case for God’s desire to be a primary attachment figure for his people.
- Have students write about or discuss the still-face experiment and how it relates to emotion regulation, unhealthy behaviors/addictions, and self-soothing.
- Have students either in groups or as a class discuss the differences and similarities between the Plutchik and Panksepp models of emotional processing.
- Ask students to discuss or write about the differences between shame and guilt and provide biblical examples, using the text, the Bible, and/or other sources. Ask if they had thought of shame and guilt this way before reading.
this chapter, and discuss how society often confuses the two and what the implications are.

- Ask students to list the seven systems of neural circuitry proposed by Panksepp and describe examples of each one for both infants and adults.
- Ask students to describe the Connect and Redirect technique, and the Name It to Tame It technique, and to reflect on their own life experiences of these dynamics in their relationships and how/if these experiences affected them.
- Ask students to come up with examples of bodily sensations that could indicate certain emotions, according to the SIFT model.

Chapter 4 Quiz (25 questions)

Fill-in-the-blank

1. Emotion lies at the heart of ____________, the driving force inherent within our most important human relationships. (attachment)
2. Our ability to navigate the wide range of emotions contained within the human experience is shaped by the quality of our connection to _______ and to our primary attachment figures. (God)
3. ________________ is a process in which shame is replaced with acceptance, fear is exchanged for a deep sense of safety, sadness is lifted through the gift of presence, and pain is soothed away by the outstretched arms of comfort. (relational soothing)
4. ________________ is defined as how much attention one gives their affective state. (attention to emotion)
5. ________________ is defined as the extent to which one understands his or her emotional experiences. (emotional clarity)
6. ____________ is a primary emotion, absent from the primary/secondary emotions model, that could be considered as a gatekeeper emotion, meaning its presence has the potential to overshadow other, less primitive emotional states. (shame)
7. Bowman cites the story of Nathan and ____________ in 2 Samuel as an example of dealing with the emotional experience of guilt in the Bible. (David)
8. ________________ is a SIT from Siegel and Payne Bryson’s model that emphasizes the importance of nonverbal, right-brain connections in identifying and eventually managing our emotional experiences. (Connect and Redirect)
9. The ____________ model involves looking to the bodily sensations for emotions that might be housed there. (SIFT)
**True/false**

1. The “still face experiment” begins with mothers and infants placed in a room together, interacting with natural, connective behaviors known as synchrony. (T/F)
2. The birth of shame manifests in the experience of becoming psychologically cut off from one’s primary attachment figure, leading to a sense of deficiency and inherent lack of worth. (T/F)
3. Bowman defines emotion as the psychological experience of being moved by a feeling toward something the individual deems important. (T/F)
4. Specificity is defined as identifying the emotion accurately. (T/F)
5. Sensitivity is defined as a synonym for sympathy. (T/F)
6. Strategies for emotion regulation depend on specificity as well as sensitivity. (T/F)
7. Parker and Thomas (2009) write, “with shame, the self was pronouncing judgement on its activity; with guilt, the self pronounced a more summary judgement on the inadequacy of the self itself.” (T/F)
8. Panksepp’s model is a “bottom-up” model of emotional processing in the brain, as opposed to a “top-down” model. (T/F)

**Multiple Choice**

1. The individual responsible for the “still face experiment” was:
   a) Tronick
   b) Plutchik
   c) Panksepp
   d) Lopez
   e) None of the above
2. Our neurobiology is designed to prioritize stimuli with:
   a) High potential for novelty
   b) Greater familiarity
   c) High primitiveness
   d) A and C
   e) A and B
3. An example of a stimulus that serves as an agent of self-soothing mentioned in the text:
   a) Food
   b) Drugs
   c) Sex
4. ____________’s 1958 model of emotion classifies emotions as primary and secondary.
   a) Lopez
   b) **Plutchik**
   c) Tronick
   d) Panksepp
   e) None of the above

5. Which of the following is NOT one of the four pairs of primary emotional experiences?
   a) Joy/sorrow
   b) **Trust/disapproval**
   c) Anger/fear
   d) Acceptance/disgust
   e) Surprise/expectancy

6. Emotional awareness is a valuable variable in accessing adaptive emotion-regulation strategies and is comprised of two features:
   a) Specificity and sensitivity
   b) **Attention to emotion and emotional clarity**
   c) Vulnerability and the therapeutic alliance
   d) None of the above

7. Parker and Thomas identify the following as affective dimensions of shame:
   a) Anger
   b) Lack of empathy
   c) Aggression
   d) Regret
   e) **A through C**
   f) None of the above

8. ____________ provide(s) a model for understanding neural circuitry and its predisposition for emotional processing, namely, through seven distinct yet interrelated systems.
   a) Plutchik
   b) **Panksepp**
   c) Parker and Thomas
   d) Bowman
   e) None of the above
9. Which of the following is NOT one of the seven systems for understanding neural circuitry and its predispositions for emotional processing?
   a) Seeking
   b) Rage
   c) Care
   d) **Trust**
   e) Play
Chapter 5
*Emotional Dysregulation Strategies* by Todd Bowman, PhD

**Key Terms:** emotion regulation, alexithymia, externalizing behaviors, auto-regulation, cognitive reappraisal, guided therapeutic imagery/visualization, diaphragmatic breathing, autogenic phrases, progressive muscle relaxation, expressive writing, relational regulation

**Key Points:**
- Bowman divides emotions into two categories: antecedent-focused, which can be implemented before distressing emotions are experienced, and response-focused, which can be utilized after the emotions are experienced.
- Neurobiology has a direct impact on one’s ability to regulate emotions.
- Two challenges to emotion regulation are alexithymia, lacking either awareness and/or ability to verbalize emotional experiences, or externalizing behaviors, using external stimuli to assuage distressful emotions.
- Alexithymia can be divided into categories, affective and cognitive.
- It is important to keep age and gender differences in mind when assessing and teaching emotion regulation strategies with clients.
- A healthy way of assuaging distressful emotions, as opposed to externalizing behaviors previously discussed, is known as auto-regulation, defined by Bowman as “the organismic experience of adaptively and effectively regulating emotion by drawing on the collectivity of internal resources, including resiliency, strengths, and internal representations of primary attachment figures” (Bowman, 2018, p. 93).
- Activating a person’s internal representation of God as a secure attachment figure through spiritual exercises such as prayer and Scripture is one beneficial way to help clients with auto-regulation skills.
- Cognitive reappraisal involves interpreting a situation in an alternative way that could lead to a different emotional experience.
- Guided therapeutic imagery/visualization is another SIT that can be used for auto-regulation, in which the counselor instructs the client to focus on images intended to relax both the brain and body.
• Breathing exercises such as diaphragmatic breathing, autogenic phrases, and progressive muscle relaxation are another beneficial set of SITs, increasing emotional awareness, blood flow, and oxygen to the brain.
• Expressive writing is another SIT for emotion regulation, and involves free-association writing, and typically involves a prompt concerning a situation or experience.
• All of that being said, relational regulation is still the strongest form of coping with emotions, “especially comforting, nonsexual touch, and gentle tone of voice paired with affirming words” (Bowman, 2018, p. 108).

Student Learning Objectives:
• To understand the challenges and considerations involved with emotion regulation, and its relationship to neurobiology
• To comprehend the relationship between auto-regulation and attachment
• To be able to describe the various SITs associated with auto-regulation

Chapter Summary:
In this chapter, Todd Bowman describes multiple SITs that are useful for helping clients learn and improve their emotion regulation abilities. Emotions are a gift from God, but they are meant to be stewarded well. Bowman divides them into two categories: antecedent-focused, which can be implemented before distressing emotions are experienced, and response-focused, which can be utilized after the emotions are experienced.

Neurobiology has a direct impact on one’s ability to regulate emotions. Ginot proposed that emotions are mainly housed in the right side of the brain, an area that attachment strongly influences. Research shows that there is now strong support for the idea that the brain and many of its functions are significantly influenced by attachment and early life experiences.

Two challenges to emotion regulation are alexithymia, lacking either awareness and/or ability to verbalize emotional experiences, or externalizing behaviors, using external stimuli to assuage distressful emotions. Examples of externalizing behaviors include alcohol, sex, drugs, media, and eating disorders, among others. However, these externalizing behaviors provide short-term relief by repressing emotions with a stronger stimulus and create long-term problems. Stronger attachment bonds, however, are associated with less externalizing behaviors and more adaptive emotion regulation abilities.

Alexithymia can be divided into categories, affective and cognitive. In the therapeutic environment, the counselor can follow a three-step strategic process to help clients who are struggling with alexithymia. This process involves helping the
client verbalize their situations, help them with cognitive appraisal, and help them discuss their emotional responses. Psychoeducation can be helpful.

Before examining some alternatives to these common and maladaptive externalizing behaviors, there are some preliminary considerations. Firstly, the alternatives must be effective and contribute to an individual’s well-being both short-term and long-term. Age and gender should also be considered, as research has shown that young adults are more likely to use maladaptive coping strategies than older adults. Additionally, one study found that teen boys and teen girls scored differently on using emotion regulation strategies; boys scored higher for positive thinking, cognitive restructuring, and acceptance, and the girls scored higher for problem-solving, emotional expression, and rumination. It is important to keep age and gender differences in mind when assessing and teaching emotion regulation strategies with clients.

A healthy way of assuaging distressful emotions, as opposed to externalizing behaviors previously discussed, is known as auto-regulation, defined by Bowman as “the organismic experience of adaptively and effectively regulating emotion by drawing on the collectivity of internal resources, including resiliency, strengths, and internal representations of primary attachment figures” (Bowman, 2018, p. 93). Activating a person’s internal representation of God as a secure attachment figure through spiritual exercises is one beneficial way to help clients with auto-regulation skills. Prayer is one of the strongest ways that we can connect to God to cope with emotional struggles; it can help us tune in to our internal representation of him, if our attachment with him is secure. Scripture is also a helpful way of connecting with God about our emotions, and can be particularly helpful if clients do not yet have a secure internal representation of him. Scripture also allows us to do our own form of cognitive restructuring, helping us base our thoughts on truth and consider our emotional experiences in new ways.

Other SITs that can be used for auto-regulation include cognitive and mindfulness-based exercises, which both seem to affect similar areas of the brain. Cognitive reappraisal involves interpreting a situation in an alternative way that could lead to a different emotional experience. The maladaptive opposite of this technique is called excessive suppression, which involves the suppression of emotional expression, as in putting on a “poker face.” Suppression, however, keeps the emotion inside, whereas healthy regulation is able to release it.

Guided therapeutic imagery/visualization is another SIT that can be used for auto-regulation. This technique is somewhat self-explanatory, and the counselor instructs the client to focus on images intended to relax both the brain and body. Bowman refers to Hall, Hall, Stradling, and Young (2006), who recommended five considerations when using this guided imagery: client expectations/assumptions, client readiness, timing, the physical environment, and any additional items that
may be needed such as paper. It is also important that the counselor informs the client that he or she can stop the exercise anytime. Guided imagery can be a beneficial coping method to replace externalizing behaviors that are harmful, whether those behaviors were aimed at up-regulating or down-regulating.

Breathing exercises such as diaphragmatic breathing, autogenic phrases, and progressive muscle relaxation are another beneficial set of SITs, increasing emotional awareness, blood flow, and oxygen to the brain. As the most basic breathing exercise, diaphragmatic breathing simply involves slowing down one’s breath. Individuals who are chronically stressed and anxiety-ridden tend to breathe fast and shallow, depriving their brains of oxygen, and this exercise can help their bodies and brains relax. However, this may create a feeling of light-headedness or dizziness for some who have not breathed slowly and deeply in a long time, so the counselor should educate the client about these potential feelings in advance, and also explain how diaphragmatic breathing can help with emotion regulation. This slow breathing calms the sympathetic nervous system, the system responsible for fight or flight emotions, and activates the parasympathetic nervous system, which assists in relaxation. Autogenic phrases are a series of relaxing phrases focusing on warmth and heaviness, repeated by the counselor to help clients regulate their emotional state. Finally, progressive muscle relaxation involves repeatedly tensing and relaxing each muscle group, helping individuals locate areas of tension and release them.

Expressive writing is another SIT for emotion regulation, and involves free-association writing, and typically involves a prompt concerning a situation or experience. James Pennebaker is one of the researchers most associated with expressive writing, his studies showing that the writing exercises resulted in higher self-reported levels of emotional and physical well-being among undergraduate college students. Bowman suggests that clients can use the SIFT model proposed by Dan Siegel during the writing process to examine any sensations, images, feelings, and thoughts that arise.

All of that being said, relational regulation is still the strongest form of coping with emotions, “especially comforting, nonsexual touch, and gentle tone of voice paired with affirming words” (Bowman, 2018, p. 108). Bowman provides a story of the birth of his son to illustrate this concept, in which his son recognized his voice and grew calm and quiet just minutes after being born. In the context of the therapeutic relationship, the counselor can help the client regulate their emotions through the power of relational connection.
Pedagogical Suggestions:

- Ask students to list as many examples of externalizing and internalizing behaviors as possible and discuss ways in which they are maladaptive over the long term; ask them to come up with a healthy behavior that is similar and could be effective enough to replace each unhealthy one.
- Have students break into pairs and role-play a counselor and a client with alexithymia, being sure to illustrate all five prominent features of alexithymia and both the cognitive and affective factors. Have a few pairs perform their dialogue in front of the class, and have their classmates write on a piece of paper each time they notice one of the five features.
- Using the text and any other sources, have students discuss as a class or in groups different ways to potentially incorporate the spiritual exercises of prayer and Scripture into the counseling process.
- Have students break into pairs or triads and role-play counseling situations involving cognitive reappraisal.
- Using the text and other sources, ask students to discuss any pros and cons of guided imagery, diaphragmatic breathing, autogenic phrases, progressive muscle relaxation, and expressive writing; ask students to brainstorm potential counseling situations in which each exercise could be helpful.
- Ask students to discuss how they would go about assessing and increasing relational regulation with their future clients.

Chapter 5 Quiz (25 questions):

Fill-in-the-blank

1. Emotion regulation is described as a family of emotion regulation strategies that may be differentiated into _____________, when the strategy intervenes before emotional responses are displayed, and _____________, when the strategy intervenes after emotional response patterns have appeared. (antecedent-focused, response-focused)
2. _____________
3. One’s capacity to regulate one’s emotional experiences well is directly tied to one’s _____________.
4. Alexithymia can be placed onto two dimensions: a(n) _____________ factor
5. and a(n) _____________ factor. (affective, cognitive)
6. _____________ can be conceptualized as the organismic experience of adaptively and effectively regulating emotion by drawing on the
collectivity of internal resources, including resiliency, strengths, and internal representations of primary attachment figures. (auto-regulation)

7. ______________ can be seen as the behaviors that increase the individual’s perception of closeness in relationship with God and serve to enhance their internal representation of him. (spiritual exercises)

8. Bowman uses the story of ___________ in the Bible to illustrate secure attachment with God. (Hagar)

**True/false**

1. Emotional processing mostly involves left-brain experiences. (T/F)
2. The function of internalizing behaviors can be defined as “the use of external stimuli to escape one’s current unpleasant emotional state.” (T/F)
3. Emotion regulation can best be defined as “all of the processes, intrinsic and extrinsic, through which individuals manage their emotions to accomplish their goals.” (T/F)
4. The idea of an internal representation is of critical importance in the process of auto-regulation. (T/F)
5. Prayer is the primary mechanism by which we spiritually connect to emotionally redirect. (T/F)
6. When there is a healthy internal representation that can be drawn on in times of stress, we are more inclined to manage our distress adaptively and effectively. (T/F)
7. Cognitive-based and mindfulness-based approaches to emotional regulation do not share overlapping regions of the brain. (T/F)
8. Cognitive reappraisal is defined as “interpreting a potentially emotion-eliciting situation in a way that changes its emotional impact.” (T/F)

**Multiple Choice**

1. Examples of externalizing behaviors include:
   a) Viewing pornography
   b) Ruminating on situations
   c) Disordered eating
   d) Video games
   e) All except B
   f) All except C

2. Healthier attachment styles lead to:
   a) Increased emotion regulation strategies
   b) Reduction of externalizing behaviors
   c) Increased coping
d) All of the above  
e) None of the above  
f) Only A  

3. ____________ have a greater tendency to use acceptance as a strategy for managing emotional situations, as opposed to maladaptive strategies.  
a) Young adults  
b) Older adults  
c) Teen boys  
d) Teen girls  
e) Toddlers  

4. ____________ scored statistically significantly higher in the use of positive thinking, cognitive restructuring, and acceptance, whereas ____________ scored higher on problem-solving strategies, emotional expression, and rumination.  
a) Teen boys, teen girls  
b) Teen girls, teen boys  
c) Older adults, young adults  
d) Young adults, older adults  

5. Which of the following are listed as prominent features of alexithymia?  
a) The reduced capacity for analyzing emotions  
b) Difficulty verbalizing emotional experiences  
c) Emotionalizing, or reduced ability to determine origins of emotions  
d) Diminished fantasy life  
e) All of the above  
f) Only A and C  

6. The spiritual SIT of __________ offers the individual an opportunity to make a different meaning of her experience of emotion and to frame her response in a different way.  
a) Prayer  
b) Scripture  
c) Meditation  
d) Mindfulness  
e) All of the above  

7. Which of the following are some results associated with cognitive reappraisal?  
a) Increased interpersonal functioning  
b) Increased emotional well-being  
c) Increased mood  
d) Increased physical energy  
e) A through C
f) All of the above
8. Perhaps the most foundational exercise that one can participate in to regulate one’s emotional state is ____________
a) Progressive muscle relaxation
b) **Diaphragmatic breathing**
c) Guided imagery/visualization
d) Autogenic phrases
e) None of the above
9. ________________ is a series of phrases that have a degree of suggestibility, with the goal of helping the client reach a state of deep relaxation by adhering to the directions indicated in each progressive phrase.
a) Progressive muscle relaxation
b) **Autogenic phrases**
c) Diaphragmatic phrases
d) Visualization phrases
e) Auto-regulation phrases
Chapter 6
Behavioral Strategies by John C. Thomas, PhD, PhD

Key Terms: behavior therapy, behavior modification, behavioral regulation, behavioral deficits/excesses, modeling, self-monitoring, shaping, successive approximation, chaining, overlearning, the “act as if” technique, role-playing, behavioral rehearsal, imaginal rehearsal, counterconditioning, exposure and response prevention (ERP) techniques, behavioral contingencies, contingency management, rewards, token economy, negative reinforcement, punishment, penalty, extinction, extinction burst, aversion therapy, response cost, covert sensitization

Key Points:

- Behavioral therapy, or behavior modification, addresses external behaviors rather than internal processes, with the goal of assisting clients to develop healthier actions.
- There are two types of maladaptive behaviors that this type of therapy seeks to address, known as behavioral regulation and behavioral deficits/excesses.
- According to the Bible, our actions matter, but we are also more than our actions.
- Modeling involves observing the behavior in another and imitating it, can be divided into three categories—covert (imagining), symbolic or in vivo (video, etc), and participant (real life)—and can also be accomplished through role play.
- Self-monitoring is a way to keep track of behavioral progress, and involves two steps: observing one’s behavior and then recording it using paper, an app, or whatever form one desires to use.
- Shaping, or successive approximation, involves breaking a task or behavior into smaller pieces that can be learned step by step.
- Chaining is a similar concept, but used for complex behaviors as opposed to the more simple behaviors that can be learned through shaping.
- Overlearning can be used as a way to help clients master the new behavior through repetition.
- The “act as if” technique is self-explanatory, and involves the client acting as if the new behavior were already learned and mastered.
Role-play is a broad term that includes such aspects as insight and attitude, and behavioral rehearsal is a specific term that emphasizes learning a particular skill.

Altering existing behaviors can be addressed through counterconditioning, exposure and response prevention (ERP) techniques, behavioral contingencies, rewards, negative reinforcement, punishment and penalty, and extinction.

**Student Learning Objectives:**

- To comprehend the Bible’s stance on actions/behavior, and how they are important, but we are more than our actions
- To understand the different types of behavioral SITs that can be used to address behavioral deficits and learn new skills
- To be able to explain the various behavioral SITs that can be used to alter existing behaviors

**Chapter Summary:**

Behavioral therapy, or behavior modification, addresses external behaviors rather than internal processes, with the goal of assisting clients to develop healthier actions. There are two types of maladaptive behaviors that this type of therapy seeks to address, known as behavioral regulation and behavioral deficits/excesses. According to Thomas, deficits are defined as “behaviors or skills that are underdeveloped in terms of frequency, intensity, or effectiveness” (Thomas, p. 111). Examples include poor hygiene and poor emotional intelligence. Excesses are the opposite of deficits and include overeating, oversleeping, and compulsivity, among others.

As Christians, it is necessary to consider the theology of behavior. The Bible does state that our actions matter, and God commands us to engage in certain actions and not engage in others. Yet, the Bible also tells us that we are more than our actions. We are made in God’s image, we are connected to each other and our environments, and we were created with agency and free will. Additionally, we were made with complexity, and our behavior has potential to display on the outside what is happening inside of us, as the Bible states that our heart is the center of everything we do. Behavior can reflect our fallenness and can also be deceptive, yet we also have the ability to control it.

One broad area of behavioral therapy is the learning of new behaviors, which can be accomplished through a variety of methods. Modeling involves observing the behavior in another and imitating it. Firstly, you as the counselor are
a model for your client. It is also helpful to help the client find another model in his or her life, anyone who seems to model the target behavior well. Modeling can be divided into three categories—covert (imagining), symbolic or in vivo (video, etc), and participant (real life)—and can also be accomplished through role play. Self-monitoring is a way to keep track of behavioral progress, and involves two steps: observing one’s behavior and then recording it using paper, an app, or whatever form one desires to use. There are many benefits to self-monitoring, including establishing a baseline, increased external and internal awareness, and efficiently tracking progress over time. Before using this SIT, consider the client’s readiness and ability to self-monitor effectively. Then, educate the client on the details of the exercise. Shaping, or successive approximation, involves breaking a task or behavior into smaller pieces that can be learned step by step. Chaining is a similar concept, but used for complex behaviors as opposed to the more simple behaviors that can be learned through shaping. When implementing shaping, choose the target behavior or goal, be sure not to under or over reinforce, and develop a list of successive approximations and conduct a task analysis. A task analysis is also known as a behavioral hierarchy, in which steps towards developing the target behavior are written out in staircase form. During chaining, the same procedure is followed for each small unit that makes up the complex behavior, and then each time a new unit is learned, all previous units up to that point are reviewed. Overlearning can be used as a way to help clients master the new behavior through repetition. The “act as if” technique is self-explanatory, and involves the client acting as if the new behavior were already learned and mastered. Role-playing and behavioral rehearsal are two other acting techniques that can be helpful for learning new behaviors. Role-play is a broad term that includes such aspects as insight and attitude, and behavioral rehearsal is a specific term that emphasizes learning a particular skill. There are five stages involved in these SITs: informed consent, choosing a goal, deciding the roles, playing the roles, and evaluating what happened. Imaginal rehearsal is similar to behavioral rehearsal, and simply involves the client imagining the behaviors occurring. Altering existing behaviors can be addressed through counterconditioning, exposure and response prevention (ERP) techniques, behavioral contingencies, rewards, negative reinforcement, punishment and penalty, and extinction. Counterconditioning involves creating a new emotional response, usually in response to a feared or disgust-inducing stimulus, to replace an existing, maladaptive emotional response. Exposure and response prevention (ERP) involves repeated exposure to the unwelcome stimulus while preventing the usual maladaptive response of fear, escape, disgust, or avoidance. This technique can be
very difficult and stressful for clients, and usually requires more time than the standard therapy hour. Informed consent must also be discussed in detail as well. Then, the counselor will teach the client relaxation techniques, create a hierarchy of situations that are triggering for the client, and ask the client to rate the situations on a subjective units of distress (SUD) scale, usually from 1 to 100. After the actual treatment, it is also important to work on relapse prevention and help the client practice the new behavior.

Behavioral contingencies, or contingency management, is a contract between the counselor and client, where the counselor rewards the desired behavior and punishes the undesirable behavior. The counselor can use a reward system, such as a token economy, where a token is given to the client each time the desired behavior is exhibited, and later the tokens can be exchanged for another type of reward. Similarly, negative reinforcement can be used, which involves strengthening a behavior by removing or avoiding an undesirable outcome. This is commonly confused with the concept of punishment, which involves an unpleasant consequence for the behavior one desires to weaken. Also similar, a penalty involves meeting the target behavior with an uncomfortable consequence. These types of therapy are also called aversion therapy. One type of aversive therapy known as covert sensitization asks the client to imagine the behavior being met with the unpleasant consequence. Extinction occurs when the behavior no longer occurs, although it is not often recommended as a therapy technique because of the difficulty level and length of time required, and is more effective if used in combination with other techniques. Sometimes extinction occurs spontaneously without an intervention as well.

**Pedagogical Suggestions:**

- Have students list as many examples as possible of behavioral deficits and excesses; make it a competition to see who can list the most.
- Have students write an essay on the theology of behavior using the information in the text, the Bible, and other sources.
- Have students break into pairs and choose one of the case studies from the text. Then have them act out the case and its associated SITs as discussed in the text as a way of practicing them. Students can also do this in triads so that one of them can observe and give feedback.
- Ask students as a class or in groups to describe the differences between shaping and chaining, and to provide examples of how each could be used in a counseling context.
- Ask students in groups or as a class to come up with a hypothetical issue and create a task analysis/behavioral hierarchy for addressing it.
• Have students break into pairs, one as the “counselor” and one as the “client,” and have the “counselor” teach the “client” about role-play and behavioral rehearsal. Then, have them actually walk through the process for a hypothetical issue as practice.
• Have students study the ERP process, break into pairs or triads, and role-play a counselor-client scene with a hypothetical issue to practice the intervention.
• Ask students to break into pairs and secretly choose a SIT from the text. Then have each pair role-play their SIT in front of the class and have the students guess which SIT is being illustrated. Make it a competition and see how quickly the audience can identify the SIT.
• Negative reinforcement, punishment, penalty, extinction, aversion therapy, and response cost can be easily confused with each other. Ask students to come up with creative ways to describe their differences, using examples if desired. Make it a competition and have students vote on who came up with the most creative descriptions.

Chapter 6 Quiz (25 Questions):

Fill-in-the-blank
1. Another generic term for behavioral therapy is ________________.
   (behavior modification)
2. Problematic behaviors that can be addressed with behavioral therapy are evident in two primary forms: ________________ and _________________. (behavioral deficits/excesses, behavioral regulation)
3. The ________________ technique involves learning new behavior by considering the behavior a reality and anticipating it as expected. (act as if)
4. ________________ is a technique used either to link aversive consequences associated with the target or to perform target behaviors through imagining them occurring. (imaginal rehearsal)
5. ________________ involves repeatedly facing one’s fear until it subsides via the process of habituation. (exposure)
6. ________________ involves inhibiting the typical avoidance or escape behaviors when in the presence of the negative stimulus. (response prevention)
7. ________________, a form of extinction, is a process by which the behavior dissipates over time without intervention. (spontaneous recovery)
**True/False**

1. Behavioral deficits describe behaviors or skills that are underdeveloped in terms of frequency, duration, intensity, or effectiveness. (T/F)
2. Whereas chaining is appropriate for learning simple behaviors, complex behaviors require shaping. (T/F)
3. A behavioral hierarchy involves constructing a staircase outlining the situations that can lead to skill development, and ranking the items to move from least complex to greater complexity. (T/F)
4. Overlearning occurs by taking a repetitive and multifaceted approach to mastering a new behavior. (T/F)
5. People often use the terms role playing and behavioral rehearsal interchangeably, though they are different. (T/F)
6. Behavioral contingencies, or contingency management, is a behavioral contract between you and the client who wishes behavioral change or needs to be changed. (T/F)
7. One use of rewards is called contingency management, which rewards clients when they display desired behaviors. (T/F)
8. Extinction is more effective when combined with other techniques that stimulate and simultaneously reinforce alternative appropriate actions such as positive reinforcement. (T/F)
9. Whereas penalty applies pain and unpleasantness, punishment applies loss of comfort. (T/F)

**Multiple Choice**

1. Which of the following statements is mentioned by Thomas when describing the theology of behavior?
   a) We are interconnected with the environment around us.
   b) We were created with moral freedom and personal agency.
   c) Behavior is soul language.
   d) **All of the above**
   e) Only b and c
   f) None of the above

2. Categories of modeling include all of the following except:
   a) Participant
   b) **Observer**
   c) In vivo/symbolic
   d) Covert
   e) None of the above

3. Benefits of self-monitoring include:
   a) Decreasing or increasing a behavior due to enhanced awareness
b) Becoming aware of internal experiences  
c) Measuring change over time  
d) All of the above  
e) None of the above  
f) Only a and c
4. Which of the following is NOT a stage involved in role-playing?  
a) Choice of scenario and identification of the goal  
b) Informed consent and client motivation  
c) Evaluation and feedback  
d) Assessment and catharsis  
e) None of the above  
f) All of the above
5. Substituting a new response (unconditioned response) for a previous response (conditioned response) and helping a client lessen anxiety by relating to a stimulus of anxiety differently is known as:  
a) Imaginal rehearsal  
b) Covert sensitization  
c) Counterconditioning  
d) Covert behavioral rehearsal  
e) None of the above
6. ______________ occurs when a behavior or response is strengthened by removing, stopping, or avoiding an aversive stimulus or unpleasant outcome.  
a) Behavioral contingency  
b) Negative reinforcement  
c) Punishment  
d) Penalty  
e) None of the above
7. ______________ occurs when the consequences of a behavior decrease the likelihood that the behavior is repeated; that is, it weakens the behavior.  
a) Negative reinforcement  
b) Punishment  
c) Penalty  
d) Response cost  
e) None of the above
8. A form of aversive therapy, ______________, requires that clients imagine scenes that pair the undesired behavior with a highly unpleasant consequence.  
a) Covert sensitization
b) Response cost


c) Imaginal rehearsal

d) Negative reinforcement

e) None of the above
Chapter 7

Behavioral Dysfunction Strategies by Stephen P. Greggo, PsyD

Key Terms: behavioral dysfunction, self-control, dysfunctional behavior, behavior, sins of commission, sins of omission, motivational dialogue, change conspiracy, unconditional positive regard, motivational interviewing, change partnership, CATs, informational support, emotional support, instrumental support, Celebrate Recovery, Alcoholics Anonymous, behavioral assessment, the A-B-C assessment technique, mindfulness, Acceptance and Commitment Therapy (ACT), willingness, FSD, rapid assessment instruments (RAIs), self-monitoring, reciprocal inhibition, systematic desensitization, skill deficit, performance deficit

Key Points:

- The purpose of behavioral dysfunction strategies is to address maladaptive and entrenched habitual behavior patterns.
- From a biblical perspective, the spiritual fruit of self-control is central to dealing with unhealthy behaviors.
- The SITs discussed in this chapter are compatible with a Christian view of dysfunctional behavior and are also the building blocks for addressing these issues in an evidence-based way.
- Motivational dialogue involves combining the unconditional positive regard concept from Rogers with a technique known as motivational interviewing (MI), for the purpose of partnering with the client in a change-conspiracy.
- Motivational interviewing was developed by William Miller and Stephen Rollnick, and is a way of asking questions and creating dialogue where the clients can talk themselves into making the changes they desire.
- It is also important to consider social support as clients are moving towards making changes. There are three types of support: informational, emotional, and instrumental, which concerns the ability of others to help with coping and moving forwards in life.
- Behavioral assessment most commonly involves the A-B-C technique, where the counselor helps the client to identify the antecedent (A), behavior (B), and consequence (C) so that the problem can be analyzed in detail.
• Learning mindfulness techniques can help clients build self-awareness to assist in the recording of behaviors.
• Willingness, a skill borrowed from Acceptance and Commitment Therapy (ACT), involves being willing to let the distressing emotions happen instead of trying to avoid them or deny them.
• Rapid assessment tools (RAIs) are extremely useful for assessing behavioral struggles; they are brief, research-supported questionnaires, and many of them are available for free in section 3 of the DSM-5 or on the DSM’s website.
• Reciprocal inhibition is the idea that a maladaptive behavior pattern can be decreased by learning a healthy, competing behavior pattern.
• Systematic desensitization is one technique that can be used for a wide variety of struggles including anxiety and anger, teaching the client to relax his or her muscles at will and thereby decrease arousal.
• It is paramount that the counselor discover and affirm the client’s own personal motivation for making changes and help him or her to be patient and cultivate self-control, as lasting change takes time.

Student Learning Objectives:
• To be able to explain the biblical view on self-control and dysfunctional behaviors, referencing Scripture
• To understand the processes and concepts involved in motivational dialogue, particularly the role of motivational interviewing (MI)
• To comprehend behavioral assessment and its associated techniques
• To be able to describe reciprocal inhibition and the concept it is based on

Chapter Summary:
The purpose of behavioral dysfunction strategies is to address maladaptive and entrenched habitual behavior patterns. From a biblical perspective, the spiritual fruit of self-control is central to dealing with unhealthy behaviors, for as Proverbs 25:28 states, “like a city whose walls are broken through is a person who lacks self-control.” However, self-control is not willpower or strong internal fortitude, as many believe it to be. Greggo (2018) defines self-control as “a series of small, nearly involuntary, rapid-fire, life-affirming decisions” (p. 136). These little decisions eventually add up to the big changes or actions that are typically associated with having self-control.

Sins can be divided into acts of commission or acts of omission, and using broad, generic language when discussing behavioral dysfunction is helpful because it can include both types of sin. Additionally, the use of broad language allows the
strategies to be applied at any developmental stage, and can include a very wide range of behaviors. The SITs discussed in this chapter, therefore, are compatible with a Christian view of dysfunctional behavior and are also the building blocks for addressing these issues in an evidence-based way. The particular SITs that are recommended in this chapter are motivational dialogue, assessment, and reciprocal inhibition.

Motivational dialogue involves combining the unconditional positive regard concept from Rogers with a technique known as motivational interviewing (MI), for the purpose of partnering with the client in a change-conspiracy. Although extremely basic, it is important for the counselor to remember that showing empathy and understanding towards the client is crucial for the client to start believing that change is possible, which is the goal of motivational interviewing. Motivational interviewing was developed by William Miller and Stephen Rollnick, and is a way of asking questions and creating dialogue where the clients can talk themselves into making the changes they desire. The counselor asks questions such as “What is awakening in you to want to make this change at this point in your life?” teasing out the client’s own values and motivations for change. The Holy Spirit’s influence can be discussed as well, if the clients are Christians. The Bible discusses the importance of putting on new, healthy behaviors and putting off destructive ones. The counselor can do this by using MI and pointing out to the client anything he says that supports commitment, activation, or taking steps, known as CATs. When clients hear themselves speaking about CATs out loud, they are more likely to put their words into actions and start putting off the old and putting on the new.

It is also important to consider social support as clients are moving towards making changes. There are three types of support: informational, emotional, and instrumental, which concerns the ability of others to help with coping and moving forwards in life. The counselor can provide these types of support, but the client will need other people as well. Different types of therapy groups or self-help groups can be considered, as well as recovery groups like Alcoholics Anonymous (AA) or Celebrate Recovery (CR), a Christian step group that is similar to AA but addresses a wide range of struggles from eating disorders to self-hate.

Another SIT is behavioral assessment for the purposes of increasing awareness, intervention, and prevention. Most commonly, an A-B-C technique is used, where the counselor helps the client to identify the antecedent (A), behavior (B), and consequence (C) so that the problem can be analyzed in detail. It is also important to use this technique to find exceptions to the problem, or situations when the problematic behavior does not occur, to help ignite hope that change is possible. In order to do this, it is wise for the client to spend a few weeks recording the behavior to gain more information.
Learning mindfulness techniques can help clients build self-awareness to assist in the recording of behaviors. In addition to recording external information on frequency, severity, and duration (FSD), clients can learn to record internal information on their emotions as well. Willingness, a skill borrowed from Acceptance and Commitment Therapy (ACT), involves being willing to let the distressing emotions happen instead of trying to avoid them or deny them. Then, the client is able to make a decision to act according to his or her values rather than reacting to their inner turmoil. Additionally, rapid assessment tools (RAIs) are extremely useful for assessing behavioral struggles; they are brief, research-supported questionnaires, and many of them are available for free in section 3 of the DSM-5 or on the DSM’s website. These mini assessments are usually criterion referenced rather than norm referenced, meaning that they reveal information about the client himself rather than the client compared to the general population. All of these techniques can help clients prepare for making changes in their lives.

Finally, reciprocal inhibition is the idea that a maladaptive behavior pattern can be decreased by learning a healthy, competing behavior pattern. This is based on the concept that two competing behaviors or states cannot exist at the same time, such as physiological tension and relaxation. Systematic desensitization is one technique that can be used for a wide variety of struggles including anxiety and anger, teaching the client to relax his or her muscles at will and thereby decrease arousal. Sometimes clients may simply be struggling with skill deficits, such as a lack of adequate social skills, that make it difficult to cease a dysfunctional behavior. In these cases, psychoeducation and support can be extremely beneficial as the counselor helps the client learn new skills. Sometimes a client does possess the appropriate skills but does not use them in every situation where they are needed; in these cases, following all three SITs discussed in this chapter in order—MI, assessment, and reciprocal inhibition—is recommended. Throughout this process, it is paramount that the counselor discover and affirm the client’s own personal motivation for making changes and help him or her to be patient and cultivate self-control, as lasting change takes time.

Pedagogical Suggestions:

- Have students as a class list as many behavioral dysfunctions as possible for which they think the techniques in this chapter would be helpful.
- Ask students in pairs or as individuals to create their own imaginary case study illustrating one or several of the techniques discussed in the chapter; students may role-play their case studies for the class, if desired, and the class could provide thoughts and feedback.
• Have students write a brief essay, or a few paragraphs, describing the Bible’s view on behavior and self-control, using the text, Scripture, and/or other sources.

• Ask students to divide into triads and role-play the case study mentioned in the text to better understand the associated SITs, or discuss the case study as a class; have students create two columns for the SITs used with Alex and with Bernice, and then explain the rationale for each one. Ask students if they can think of any additional SITs that could be useful for this case.

• Have students break into pairs or triads (if an observer is desired) and research motivational interviewing online. Then, have them practice motivational interviewing questions on each other.

• Ask students to list concrete examples for each type of social support mentioned in the text to better understand each one: informational, emotional, and instrumental. Ask them how they would go about helping a client locate and utilize each type of support, and how they could also provide each type themselves as a counselor.

• Assign students to visit a local Alcoholics Anonymous, Celebrate Recovery, or other similar support group and write a report about what they learned. Discuss as a class.

• Have students break into pairs and play the roles of counselor and client. Have the “client” create an imaginary issue and the “counselor” practice using the A-B-C assessment technique, then switch roles and repeat.

• As homework, have students choose a behavior from their own life that is relatively mundane (such as watching too much NetFlix or drinking too much coffee) but that the student would like to change, and use the A-B-C model (and other behavioral assessments discussed in the chapter if desired) to track and record the behavior over the course of a week or two. Then, have them share any insights they gained with the class, or write about them in a report or essay.

• Have students familiarize themselves with section 3 of the DSM-5 and the DSM website (the RAI’s). Have students break into pairs and role-play giving the assessments to each other as counselor and client (and interpret the results afterwards), for the purposes of becoming comfortable with them and understanding how they work.

• Ask students as a class to think about reciprocal inhibition and come up with a list of potential competing behaviors for various dysfunctional behavior patterns.
Chapter 7 Quiz (25 questions):

Fill-in-the-blank
1. ___________ is described as a series of small, nearly involuntary, rapid-fire, life-affirming decisions. (self-control)
2. When clinicians use the term ___________, they mean observable, overt action as well as covert happenings, that is, internal activity. (behavior)
3. In ______________, a change partnership is formed with the client by locating and surfacing what the client currently values, desires, and is ready to do. (motivational interviewing)
4. ______________ support describes how the involvement of others increases coping skills, endurance, or the momentum to push forward. (instrumental)
5. ______________ support is guidance from others about resources, perspectives, or practical opportunities. (informational)
6. In the A-B-C assessment technique, the A stands for ______________. (antecedents)
7. ______________ entails accepting and letting inner states, even drastically uncomfortable ones, occur instead of avoiding them in various ways. (willingness)
8. _____________ is a term carried over from the first wave of behavior therapy, denoting two contradictory or incompatible physiological responses. (reciprocal inhibition)

True/False
1. This chapter aims at helping therapists foster change in deep-seated and troublesome habits. (T/F)
2. Motivational interviewing (MI) is a style of dialogue in which the counselor talks the client into change. (T/F)
3. The abbreviation CAT stands for commitment, activation, or taking steps. (T/F)
4. Celebrate Recovery is a step group for Christians that bears little resemblance to other step groups such as Alcoholics Anonymous. (T/F)
5. When using assessment techniques, a deliberate effort should be made to notice exceptions or breaks in the ordinary unwanted behavioral chain. (T/F)
6. Rapid assessment interventions (RAIs) are norm based rather than criterion based. (T/F)
7. The treatment principle based on reciprocal inhibition is that it is feasible to decrease undesired behavior by increasing a competing one. (T/F)
8. Anger management protocols often make use of systematic desensitization, because anger is often accompanied by a physiological state of arousal. (T/F)

9. Counselors strive to affirm and fortify a client’s own recognition and motivation that change is possible. (T/F)

Multiple Choice

1. Greggo discusses the spiritual fruit of ____________, and in Proverbs the lack of it is compared to a city whose walls are broken through.
   a) Patience
   b) Self-control
   c) Peace
   d) Faithfulness
   e) None of the above

2. Benefits of using generic behavioral language, according to the text, include:
   a) Strategies can be applied nicely across the full developmental lifespan.
   b) Behaviors can be captured theologically as sins of commission or omission.
   c) Personal interpretations and applications can be utilized by the counselor.
   d) All of the above
   e) Only A and B
   f) Only A

3. Motivational interviewing (MI) was developed by:
   a) Miller and Rollnick
   b) Greggo and Egan
   c) Rogers
   d) Saddleback Church
   e) Alex and Bernice

4. Which of the following is a type of social support mentioned in the text?
   a) Informational support
   b) Technical support
   c) Emotional support
   d) Instrumental support
   e) Physical support
   f) A, C, and D
   g) A, C, and E
   h) All of the above

5. Becoming aware of fluctuating inner states so that a more deliberate course of action can be taken is known as:
   a) Acceptance and Commitment Therapy (ACT)
6. ______________ is an example of reciprocal inhibition in action.
   a) Acceptance and Commitment Therapy (ACT)
   b) Progressive muscle relaxation
   c) **Systematic desensitization**
   d) Mindfulness training
   e) All of the above
   f) None of the above

7. When a client possesses a skill but does not use it in every situation in which it is needed, this is known as:
   a) Skill deficit
   b) Skill excess
   c) **Performance deficit**
   d) Action deficit
   e) None of the above

8. When a client possesses a skill but does not use it in every situation in which it is needed, the best approach, according to the text, is:
   a) **Motivational dialogue followed by assessment and reciprocal inhibition**
   b) Motivational dialogue followed by reciprocal inhibition
   c) Psychoeducation and support
   d) Psychoeducation, motivational dialogue, and assessment
   e) None of the above
Chapter 8

Experiential Strategies by John C. Thomas, PhD, PhD

Key Terms: experiential strategies/techniques, ordeal therapy, sculpting, process, parables, metaphors, phototherapy, sand tray, psychodrama, equine therapy, wilderness and adventure therapy, props, provocation, exaggeration, paradox, jesting, life and trauma egg, angel egg, rituals, experiential writing techniques, insight journaling, experiential vocalizing technique, voice therapy

Key Points:

- The purpose of experiential strategies is to draw out deep inner issues and emotions, and to thereby help clients grow in self-awareness.
- In 1984, Haley created ordeal therapy, in which an inconvenient, difficult, and undesirable ordeal is constructed for the client to perform every time the issue emerges. The intent is for the ordeal to be so irritating that the client gives up or decreases the frequency or severity of the issue in order to avoid the ordeal.
- Thomas (2018) points out that both God and the prophets use various “ordeals” or other experiential techniques throughout the Bible as a way of addressing maladaptive behaviors.
- There are many benefits to using experiential strategies, and they can be used with all populations and with all types of therapeutic methodologies.
- It is important to be willing to ethically move outside one’s comfort zone when considering or using these techniques, as many of them are bold and different from the norm.
- Examples of experiential strategies include parables and metaphors, writing activities, phototherapy, poetry, music, art, sand trays, dance, sculpting, psychodrama, equine therapy, wilderness and adventure therapies, using props, using directives, and using ordeals.
- Metaphors and parables can be created by either the counselor or the client, and they can be spoken or written. There are two types of metaphors: story-telling and process-depicting.
• Provocation involves using unconventional techniques to “provoke” a client to discover/reveal a deeper issue that is outside the client’s conscious awareness.
• Examples of prevocational techniques include playing devil’s advocate, siding with the client’s assertions, exaggeration, paradox, jesting, sarcasm, putting the client in a crucible, and suggesting ridiculous ideas or solutions.
• The life and trauma egg originates from Murray’s and Carnes’s 1997 work, and involves drawing an egg with symbols inside of it to represent different traumatic events in a client’s life.
• There are also expressive experiential techniques such as creative writing, journaling, insight journaling (in which the client journals about himself), letter writing, and poetry.
• Additionally, the experiential vocalizing technique, or voice therapy, was developed by Firestone in 2001, and helps clients to vocalize their inner critic and thereby release internal emotions.
• Music and art can also be helpful experiential techniques, and younger generations in particular seem to desire these types of nonverbal expression.

Student Learning Objectives:
• To understand the purpose, benefits, hesitations, and preparatory skills involved in experiential strategies
• To be able to explain the use of experiential strategies throughout the Bible and to provide scriptural examples
• To be able to describe the various experiential strategies discussed throughout this chapter and any steps, guidelines, or benefits involved

Chapter Summary:
The purpose of experiential strategies is to draw out deep inner issues and emotions, and to thereby help clients grow in self-awareness. Other words that are sometimes used interchangeably with experiential include unconventional, nontraditional, creative, and prevocational. Experiential strategies address experience, which includes both internal and external, and are well-supported by a Christian worldview.

In 1984, Haley created ordeal therapy, in which an inconvenient, difficult, and undesirable ordeal is constructed for the client to perform every time the issue emerges. The intent is for the ordeal to be so irritating that the client gives up or decreases the frequency or severity of the issue in order to avoid the ordeal. Thomas (2018) points out that both God and the prophets use various “ordeals” or other experiential techniques throughout the Bible as a way of addressing
maladaptive behaviors. Moses, Jacob, and Abraham all received experiential treatment from God, as did Elijah and Naaman. Jesus used several experiential techniques through his miracles and teachings. Worship itself can also be seen as an experiential activity.

There are many benefits to using experiential strategies: (1) they engage all of the senses at once; (2) the client’s experience can be directly observed in the session; (3) experience is the best way to learn; (4) abstract concepts can be made concrete for clients; (5) they create greater self-awareness and insight; (6) they can clearly emphasize a point; (7) they foster healing by increasing intensity; (8) they work beneath the surface of conscious awareness, decreasing resistance; and (9) they can foster spiritual growth. They can be used with all populations and with all types of therapeutic methodologies.

It is important to be willing to ethically move outside one’s comfort zone when considering or using these techniques, as many of them are bold and different from the norm. Cultivating creativity and versatility are necessary, as well as furnishing one’s office with several types of props such as cups, shields, paper, or extra chairs. Timing is important, but the client’s willingness to engage with experiential strategies is more important. It is also recommended to focus on staying with the client during experiences and identifying/discussing the process of the experience rather than simply the content. Noticing what the client is not saying and observing the client’s body language, or asking the client where he feels particular experiences or emotions in his body, can be helpful ways to discuss the process. Video recording a session can also be helpful, so that the client can observe himself.

Examples of experiential strategies include parables and metaphors, writing activities, phototherapy, poetry, music, art, sand trays, dance, sculpting, psychodrama, equine therapy, wilderness and adventure therapies, using props, using directives, and using ordeals. Metaphors and parables can be created by either the counselor or the client, and they can be spoken or written. There are two types of metaphors: story-telling and process-depicting. Story-telling metaphors, like parables, tell stories to illustrate a particular point or truth. Process-depicting metaphors can be constructed by counselor or client as well, and can be analogies for a client’s emotional experiences.

Props are a way to help clients learn, as props tend to be even more memorable than words. Anything can be used as a prop, and it provides a visual way to explain a concept. In phototherapy, clients can bring in photos that illustrate their lives. Often clients will initially bring photos that represent difficult times. Clients can also use photos to illustrate their stories or explain ideas. Sand tray therapy involves a tray of sand and a wide variety of miniatures, which the client
can use to depict their experiences. Though typically a part of play therapy for children, they are also effective and fun for adults.

Provocation involves using unconventional techniques to “provoke” a client to discover/reveal a deeper issue that is outside the client’s conscious awareness. Examples of prevocational techniques include playing devil’s advocate, siding with the client’s assertions, exaggeration, paradox, jesting, sarcasm, putting the client in a crucible, and suggesting ridiculous ideas or solutions. Provocation can hurt emotionally in the moment, but one must remember to always do no harm, as is stated in the ethical codes. When employing these techniques, there are six guidelines one should follow: (1) make sure the technique is consistent with one’s view of behavior; (2) explain and obtain informed consent from clients to use these types of techniques; (3) ensure that the therapeutic bond is strong; (4) ensure that there is respect for the client; (5) explain the particular technique to clients and ensure the client’s permission; and (6) receive supervision.

More structured experiential techniques include the life and trauma egg, and rituals. The life and trauma egg originates from Murray’s and Carnes’ 1997 work, and involves drawing an egg with symbols inside of it to represent different traumatic events in a client’s life. This can also be done for positive events instead. Then, the client will create outside of the egg a list of family rules, family roles, a list of words to describe his mother, and a list of words to describe his father. This is often assigned as homework but can also be completed in a session. Rituals can also be assigned as homework or in session to provide insight into relational dynamics; this technique is particularly used with families.

There are also expressive experiential techniques such as creative writing, journaling, insight journaling (in which the client journals about himself), letter writing, and poetry. Additionally, the experiential vocalizing technique, or voice therapy, was developed by Firestone in 2001, and helps clients to vocalize their inner critic and thereby release internal emotions. Five steps are recommended by Firestone to guide the counselor through the use of this technique, and involve identifying destructive thoughts and behaviors, obtaining insight from them, assisting the client in countering or speaking back to the critical inner voice, and brainstorming positive ways to address these destructive thoughts or behaviors. Music and art can also be helpful experiential techniques, and younger generations in particular seem to desire these types of nonverbal expression.

**Pedagogical Suggestions:**
- Have students list (or act out) as many characters and stories from the Bible they can think of that illustrate experiential strategies; make it a competition and see who can list the most.
• The text mentions several benefits and hesitations involved with using experiential strategies. Have students as a class or in groups discuss their thoughts and feelings associated with experiential work in light of this information.
• Have students break into groups, choose one of the case studies discussed in the text, and role-play it for the class; ask the class for feedback, and discuss the SITs that were illustrated. This can also be assigned as homework so that students can better familiarize themselves with the cases and SITs.
• Have students break into pairs or triads, pick one or two (or several) of the experiential techniques listed on page 164 of the text, and create a role-play to illustrate them. If done in triads, the third person can be an observer and provide feedback.
• Ask students as a class to create a master list of potential props that could be helpful and creative ways they could be used.
• Ask students as a class to list various issues that they think could be addressed with any of the techniques mentioned in the text and explain their rationales. Perhaps write them all on the board and create a master list.
• Have students practice phototherapy by creating a short photo presentation on something positive from their own lives. These can be photos that represent happy memories or photos that represent favorite scenes or places, etc.
• Have students break into pairs or triads and role-play using provocation techniques as listed in the text to help them grow more comfortable with how uncomfortable some of these techniques may feel.
• To illustrate the concept of the life and trauma egg, but without triggering any trauma, ask students to create their own “angel eggs” depicting all the positive, happy events that have happened throughout their lives. This can be done in class or assigned as homework. Then, have them write a few short paragraphs about their experience and potential ways they could use this exercise with future clients.

Chapter 8 Quiz (25 questions):

Fill-in-the-blank
1. When the bodies of clients are placed in postures that can activate self-awareness into their functioning within a system, this technique by Virginia Satir is known as ____________. (sculpting)
2. ________________ can be used as visual analogies to represent concepts. (props)
3. _______________ is an expressive and projective technique whereby the client creates a psychological representation of his inner and outer life using objects and miniatures. (sand tray therapy)

4. _______________ involves “calling out” various aspects of the client’s experience through a number of particularly nontypical techniques. (provocation)

5. “If you don’t study for your upcoming math test, we will have a better idea of what would happen if you actually fail” is an example of _______________, a provocation technique. (paradox)

6. “Perhaps changing is too much work” is an example of _______________, a provocation technique. (playing devil’s advocate)

7. “It sounds like you must be awfully special. Everyone else is allowed to be human and make mistakes, but not you” is an example of _______________, a provocation technique. (sarcasm)

8. Murray and Carnes are known for developing ________________, (the life and trauma egg)

True/False
1. Experience consists only of the external (relationships and environment) world. (T/F)
2. Experiential techniques cannot be used with all populations and therapy formats. (T/F)
3. Processes are experienced viscerally. (T/F)
4. There are two types of metaphors: storytelling and those that depict client processes. (T/F)
5. Sand tray therapy is typically considered a play therapy activity for children only and is not effective with adults. (T/F)
6. Insight journaling is a type of journaling that focuses on exploring the self. (T/F)
7. Firestone developed voice therapy, or the experiential vocalizing technique, in 2001. (T/F)
8. Younger generations seem to find meaning in art forms more than in words. (T/F)
9. Experiential work bridges the heart-head divide. (T/F)

Multiple Choice
1. _______________ is the creator of ordeal therapy.
   a) Haley
   b) Thomas
   c) Firestone
d) Murray  
e) None of the above  

2. The text mentions that the following individuals were involved with experiential strategies in the Bible except:
   a) Abraham  
b) Moses  
c) Mary  
d) Jesus  
e) Elijah  

3. Which of the following is NOT one of the benefits of experiential techniques?
   a) Provides a holistic, multisensory approach  
b) Provides in-moment observation  
c) We learn through experience  
d) Counseling becomes more concrete  
e) None of the above  

4. Which of the following is NOT listed as one of the recommended preparations for experiential work?
   a) Supply your office with necessities.  
b) Be versatile.  
c) Be brave.  
d) Develop creativity.  
e) None of the above  

5. Which of the following is NOT listed as one of the recommended in-session considerations for experiential work?
   a) Stay with  
b) Identify client processes  
c) Assess the selection of client material  
d) Train the client in mindfulness or relaxation techniques  
e) None of the above  

6. Which of the following is NOT listed as a provocation technique?
   a) Putting the client in a crucible  
b) Sarcasm  
c) Paradox  
d) Exaggeration  
e) Minimizing  
f) None of the above  

7. Which of the following is NOT one of the conditions necessary for using provocation techniques?
   a) You must possess deep respect for the client.
b) The techniques must be consistent with how you understand behavior.
c) Informed consent
d) Obtain supervision
e) Obtain insurance approval
f) None of the above

8. Which of the following is NOT one of the steps mentioned by Firestone involved in the process of voice therapy?
   a) Identify negative thought patterns and processes.
   b) Respond to and resist the voice.
   c) Glean insights into the origins of the negative thoughts.
   d) Collaborate on ideas to address the negative patterns.
e) None of the above
f) All of the above
Chapter 9
*Spiritual Strategies* by Fernando Garzon, PsyD

**Key Terms:** Scripture, Christian meditation, worship, solitude and silence, forgiveness, Christian inner healing prayer (CHP), the Immanuel approach, spiritual assessment, informed consent

**Key Points:**
- Spiritual strategies discussed in this chapter include Scripture, Christian meditation, Bible reading and memorization, worship, solitude and silence, forgiveness, and Christian inner healing prayer.
- In past decades, those in psychological circles often debated whether spirituality was good or bad. Currently, the psychology world is trying to investigate how spirituality can be beneficial and also how it can cause harm.
- Informed consent and spiritual assessment are imperative.
- Typical hesitations/misconceptions about meditation include believing that meditation originates from Eastern religions and is therefore not Christian, meditation is New Age because it involves using the imagination, and meditation empties one’s mind and opens one up to demonic influence.
- Worship is a spiritual strategy that is rarely mentioned in the clinical literature and rarely employed by counselors, perhaps because of the variability among denominations or fear of the client looking to the counselor as his main spiritual leader.
- Forgiveness is highly supported in the clinical literature, but many clients misunderstand it, and therefore an assessment for and a discussion of these misconceptions is imperative before suggesting this strategy.
- The Enright model of forgiveness is emphasized in this chapter, involving four non-linear phases known as uncovering, decision, working, and deepening.
- Christian inner healing prayer (CHP) models aim to help the client process traumatic memories by facilitating a conversation between the client and God.
Most CHP programs require formal training and supervised practice hours, so this strategy should not be employed without such training, especially if the client is struggling with PTSD, dissociation, or substance abuse.

The Immanuel approach was developed by Karl Lehman, and is based on attachment theory, eye-movement desensitization and reprocessing therapy (EMDR), and neuroscience.

Student Learning Objectives:
- To be able to explain the differences between psychology’s definitions of spirituality and Christianity’s definitions of spirituality
- To understand the processes and steps involved with the spiritual strategies of Scripture, Christian meditation, Bible reading and memorization, worship, solitude and silence, forgiveness, and Christian inner healing prayer.

Chapter Summary:
Spiritual strategies discussed in this chapter include Scripture, Christian meditation, Bible reading and memorization, worship, solitude and silence, forgiveness, and Christian inner healing prayer. Before examining these techniques, it is helpful to define spirituality according to the world of psychology and according to Christian theology.

In past decades, those in psychological circles often debated whether spirituality was good or bad. Currently, the psychology world is trying to investigate how spirituality can be beneficial and also how it can cause harm. Spirituality is broadly defined as the search for something beyond the self. While there are many different types of spirituality, they have two things in common: (1) they all believe that the spirit exists, and (2) they all possess a heterogeneous nature, or are all different. In the world of Christianity specifically, spirituality is multi-factorial, and Garzon (2018) refers to Tan’s descriptions to illustrate the concept. Tan asserts that Christian spirituality is based on a desire for God and a relationship with him founded on love, which results in worship, obedience, surrender, being filled with the Holy Spirit, engaging in sin less as one grows in the process of sanctification, and communal and individual spiritual disciplines. Christian spirituality is eternal, not temporary, and includes phenomena such as spiritual warfare and mystical experiences.

Before using any spiritual strategies, it is necessary and ethical to explain and obtain a thorough informed consent, both orally and in written form. A helpful way to do this is to include a paragraph describing one’s training in these spiritual interventions and/or one’s Christian history in the standard informed consent form. It is also necessary to conduct a spiritual assessment, assessing for elements such
as denomination, spiritual activities such as prayer and reading Scripture, and church attendance. Questions about these elements can easily be slipped into the standard assessment of a client’s cultural background in the beginning stage of counseling. If desired, short, formal questionnaires can be used, such as the Religious Commitment Inventory or the Theistic Spiritual Outcome Survey. Because Christians can sometimes tend to use the word “should” a lot—“I should read my Bible more”—and experience religious self-condemnation and shame, all spiritual strategies employed in counseling must be conducted with an attitude of grace. The counselor can discuss the concept of grace explicitly with the client in order to assess the client’s current understanding of it and to examine the truth about grace as displayed in Scripture, which is a spiritual strategy itself. The counselor can use Scripture in the session itself or assign readings or verses as homework between sessions. However, there are a few key points one must keep in mind when using this spiritual SIT: (1) the counselor must know the Bible well; (2) the counselor must embody the spiritual concepts being discussed in the session to illustrate them implicitly for the client; (3) it is important to connect the truths learned through Scripture to situations in the client’s life, and (4) realistic Scripture readings or verses are to be assigned to the client as homework.

Christian meditation is another spiritual SIT that can be useful, but Christian clients may have some hesitations when the word “meditation” is mentioned. Typical hesitations include believing that meditation originates from Eastern religions and is therefore not Christian, meditation is New Age because it involves using the imagination, and meditation empties one’s mind and opens one up to demonic influence. Therefore, Christian meditation must be accurately explained by the counselor. The Bible has many references to Christian meditation, and many prominent figures in church history across denominations are known for practicing meditation. Christian meditation is different from Eastern religious meditation in that Christians believe in the immanence of God; it focuses on thinking about God’s character or dwelling on verses of Scripture rather than emptying one’s mind. If clients are worried that imagery is only a New Age tool, it can be helpful to explain different ways we use our imagination every day, and also talk about how our imaginations can be yielded to God. When demonic influence is a concern, the counselor can discuss authority in Christ and prayer for protection before meditating.

Meditating on the truths of Scripture can help clients to quietly reflect without distractions, and involves the following steps, although they can be tailored individually: (1) ask the client to choose a verse or biblical phrase; (2) instruct the client to sit in a comfortable position; (3) ask the client to close his eyes or find a spot in the room to look at; (4) instruct the client to breathe in and out slowly while repeating the verse or phrase a few times; (5) repeat this process;
(6) ask the client to think about the verse or phrase and how it could apply to his life; (7) remind the client it is normal for his mind to become distracted during this exercise; and (8) ask the client if he would like to write down or discuss any of the insights he gained during the exercise. The stress break technique can also be used, in which the client writes the verse or phrase on an index card or in his phone and pulls it out to read during stressful times in his day. Scripture can also be discussed in session as part of cognitive restructuring, or the counselor can help the client learn strategies for Scripture memorization. When doing this, it is helpful to be creative, examine the client’s typical day for areas of time where memorization could be practiced, utilize technology if desired, and ask the client to involve other people in his life.

Worship is a spiritual strategy that is rarely mentioned in the clinical literature and rarely employed by counselors, perhaps because of the variability among denominations or fear of the client looking to the counselor as his main spiritual leader. These concerns can be addressed by careful assessment during all stages of the counseling process and during/after the spiritual exercises, as well as openly addressing them if they arise. Silence and solitude are also helpful strategies, involving shutting out all distractions to focus on God’s presence and action in one’s life. However, diagnostic features should always be considered before using this strategy. Those with borderline personality disorder, post-traumatic stress disorder (PTSD), or poor coping skills are usually reactive to being alone and should not be considered for these exercises.

Forgiveness is highly supported in the clinical literature, but many clients misunderstand it, and therefore an assessment for and a discussion of these misconceptions is imperative before suggesting this strategy. The counselor can discuss how forgiveness does not mean reconciliation or saying that the other person’s actions should be excused or tolerated. There are two empirically supported forgiveness models in the literature, one by Enright and one by Worthington. The Enright model is emphasized in this chapter, involving four non-linear phases known as uncovering, decision, working, and deepening. In the uncovering phase, the client learns to analyze the defense mechanisms he is using to deal with the pain and ask himself whether these are helping him or hurting him. In the decision phase, the client learns that the defense mechanisms are hurting him and considers forgiveness as a possibly better alternative. In the working phase, the client learns to see the situation and offender in a different way through the eyes of compassion, perhaps using Gestalt techniques. Finally, in the deepening phase, the client learns to consider suffering and humanity in general and reflect on forgiveness for both himself and others in the world. The counselor should watch for spiritual bypass, a phenomenon in which clients over-spiritualize in order to avoid pain, particularly in the working and deepening phases.
Finally, Christian inner healing prayer (CHP) is another helpful strategy, and many different models exist. Typically, they all aim to help the client process traumatic memories by facilitating a conversation between the client and God. Most CHP programs require formal training and supervised practice hours, so this strategy should not be employed without such training, especially if the client is struggling with PTSD, dissociation, or substance abuse. Additionally, the counselor must always be nondirective when using this strategy so as not to implant any false memories. The text discusses the Immanuel approach as an example to illustrate the strategy. The Immanuel approach was developed by Karl Lehman, and is based on attachment theory, eye-movement desensitization and reprocessing therapy (EMDR), and neuroscience. The client begins by visualizing a positive memory and inviting God’s presence into the memory. The counselor can ask the client what he is seeing, feeling, or experiencing. Then, the client asks God which memory he would like him to address in the session, and it is usually a painful one. The counselor guides the client through the same process used with the positive memory, and the client can ask God what he wants to show him about the memory. The counselor then ends the session by asking the client to return to the positive memory. Sometimes this process takes only one session, but it can be used across multiple sessions as well. After a session, the counselor can ask the client what the process was like for them and if they have any questions or concerns they would like to discuss.

**Pedagogical Suggestions:**

- Have students break into pairs and practice verbally explaining informed consent for spiritual strategies to a hypothetical client. Ask them to write a sample paragraph or two that they can use in their own future informed consent forms concerning spiritual strategies, following but not copying the example given in the text.
- Have students break into pairs and practice using spiritual assessment questions in a hypothetical intake session. Ask them to also do an online search for spiritual assessment questionnaires other than the two mentioned in the text and share their findings with the class. If the questionnaires are available in the public domain, have students practice giving them to a hypothetical client through role-playing.
- Have a class discussion on the definitions and common misconceptions of grace, using Scripture and other sources. Ask students to each come up with their own personal definition of grace and write it out in their own words. Ask students to describe ways they could practically display their definition of grace with their future clients.
• Have students discuss as a class or in groups their own views on Christian meditation and how or if those views have changed since reading the chapter. Ask them to discuss any personal experiences they have had with meditation and if there are any common misconceptions they can think of that are not listed in the text.

• Have students practice the stress break technique by writing down a verse or biblical phrase on an index card or in their phone and reading it throughout their days during times of stress or anxiety. Ask students to take the suggestions for helping busy clients memorize Scripture in the text and apply them to their own lives for one week as if they were their own client. At the end of the week (or two), have students discuss or write a report on their experiences and how they could use such strategies with future clients.

• Discuss the concept of forgiveness as a class or in groups. Ask students if they identify with any of the misconceptions mentioned in the text and why. Ask that they support their opinions with Scripture.

• Assign students to research the forgiveness models mentioned in the text and to write a paper or discussion board post describing the similarities and differences.

• Assign students to research Christian inner healing prayer models and to write a paper or discussion board post describing the similarities and differences. Have each student pick one model to describe in detail and explain the training procedures and concepts involved.

Chapter 9 Quiz (25 questions):

Fill-in-the-blank

1. __________, in the psychological sense, has been defined as the search for that which transcends the self, or the search for the sacred. (spirituality)

2. Cashwell and Giordano (2014) propose the following common link between spiritualities: _________ exists. (spirit)

3. Before employing spiritual strategies, the counselor ethically must utilize informed consent and spiritual _______________. (assessment)

4. Two forms of Christian meditation supported by Scripture involve meditating on small portions of Scripture and meditating on ________________. (God’s character)

5. Variability among denominational expression and fear of the client viewing the counselor as his main spiritual leader are associated with the hesitancy many counselors may have prescribing the spiritual strategy of ________. (worship)
6. There are two empirically supported models of forgiveness, one developed by ________________ (Enright)
7. and one developed by ___________________. (Worthington)
8. The psychiatrist Karl Lehman developed the Christian inner healing prayer strategy known as _________________. (the Immanuel approach)

True/False
1. In the physical and mental health fields, the question has shifted from understanding the conditions in which spirituality promotes health and those conditions in which it may harm well-being to whether spirituality is good or bad. (T/F)
2. The Religious Commitment Inventory and the Theistic Spiritual Outcome Survey are examples of spiritual assessment measures. (T/F)
3. When using the Bible in session or as client homework, it is not necessary for the counselor to know the Bible well himself. (T/F)
4. Meditation is clearly mentioned in Scripture. (T/F)
5. Christian meditation involves emptying the mind. (T/F)
6. Research suggests that mental health professionals often recommend worship as a practice for their clients. (T/F)
7. Individuals who struggle with borderline personality disorder and post-traumatic stress disorder (PTSD) are excellent candidates for silence and solitude. (T/F)
8. Forgiveness means excusing the actions of the offender. (T/F)

Multiple Choice
1. Which of the following is NOT listed in the chapter as a spiritual strategy?
   a) Solitude and silence
   b) Communion
   c) Forgiveness
   d) Scripture
   e) None of the above
2. Which of the following is NOT one of Tan’s factors in Christian spirituality?
   a) A response of worship and desire to obey God’s good will
   b) Being filled with the Holy Spirit
   c) The nonlegalistic practice of the spiritual disciplines
   d) A deep hunger for God
   e) None of the above
3. According to the text, Christians can be vulnerable to living in the land of:
   a) Would
   b) Could
4. Which of the following is listed as a recommended consideration when using the Bible in session or as homework?
   a) Small, realistic homework assignments
   b) Connecting the biblical concepts to the client’s life situations
   c) Knowing the Bible well yourself
   d) Implicitly embodying biblical concepts such as grace and compassion
   e) **All of the above**
   f) Only A and B
   g) Only A through C

5. Which of the following is NOT listed as a concern that many clients may have about meditation?
   a) Meditation is from Eastern religions and is not Christian.
   b) Meditation involves guided imagery and is therefore New Age.
   c) Meditation opens one up to demonic influence.
   d) Meditation is “too hard” and “ain’t nobody got time for that.”
   e) None of the above

6. Which of the following is NOT one of the recommendations for using Bible reading and memorization with “busy” clients?
   a) Ask the client to involve others.
   b) Be creative.
   c) Assess the client’s daily routine.
   d) Use technology and simple props.
   e) **Teach the client discipline and motivation skills.**
   f) None of the above

7. Which of the following is NOT listed as a common misconception about forgiveness?
   a) Forgiveness means reconciliation.
   b) Forgiveness means tolerating the offender’s behavior.
   c) Forgiveness means excusing the offender’s behavior.
   d) Forgiveness means condoning the offender’s behavior.
   e) **None of the above**
   f) Only B through D

8. Which of the following is listed as one of the phases in Enright’s forgiveness model?
   a) **Deepening**
   b) Quickening
   c) Identifying
d) Locating
e) All of the above
f) None of the above

9. The ______________ phase in Enright’s forgiveness model involves reframing the incident and exploring the larger context in terms of the offender and the situation.
a) Deepening
b) Working
c) Exploration
d) Quickening
e) Identifying
f) Locating
g) None of the above
Chapter 10

*Christian Formation of the Self Strategies* by Ian F. Jones, PhD, PhD

**Key Terms:** Descartes, Forster, Vande Kemp, Delitzsche, Clebsh and Jackle, healing, sustaining, guiding, reconciling, Maslow’s hierarchy of needs, Rogers, person-centered psychotherapy, Cooley, looking-glass self, Mead, the imitative stage, the play stage, the game stage, Goffman, Webb-Mitchell, individualism, universalism, Fowers, Barna, character development, Levinson, the young-old polarity, the destruction-creation polarity, the masculine-feminine polarity, the attachment-separateness polarity, soul growth, prayer, meditation, spiritual disciplines, cognitive disciplines, behavioral disciplines, interpersonal disciplines, worship disciplines, healing disciplines, McMinn, Leaf, Garner

**Key Points:**

- According to the Bible, a biblical view of the self is based on the foundation of the self being made in the image of God and possessing a body, a spirit, and a soul.
- Descartes, a seventeenth century philosopher, brought the self to the center of philosophical inquiry. Descartes postulated that God is not personally involved in human lives.
- Jonathan Langstaff Forster emphasized the idea of taking a biblical view of the self and the soul in 1873, standing in contrast to other philosophers of his time who viewed the body and the soul as separate, unrelated, and opposite elements.
- In 1912, Fletcher emphasized the idea of biblical psychology and stated that the foundation of this view is God’s role in our original and current existence.
- Concerning biblical counseling, there are four historical elements, as suggested by Clebsch and Jackle in 1964: healing, sustaining, guiding, and reconciling.
- In the 1960s, counseling and psychology began to focus on the self from a humanistic perspective.
Cooley (1902) coined the term “looking-glass self” to illustrate how the self is formed and seen through the responses of others. Mead (1934) also believed that the self cannot develop apart from social interactions, and divides the self into two parts known as “I” and “me.” The “I” is the raw material of the self, and the “me” is the part that is formed socially. The full self develops through interactions between the “me” and the “I.”

According to Levinson (1978), there are four polarities involved in the midlife-crisis: (1) the young-old polarity, (2) the destruction-creation polarity, (3) the masculine-feminine polarity, and (4) the attachment-separateness polarity.

Some spiritual SITs that can help with Christian formation and development of the self include various prayers, such as prayers of thanksgiving; confession; seeking God’s blessing, peace, and protection; petition; intercession; asking God for words and opportunities to speak them; contemplation; and listening.

Spiritual disciplines such as reading, meditation, suffering, community, worship, confession, forgiveness, godly actions, and many others can be helpful as well.

It can also be beneficial to help the client develop a godly attitude towards life and self, particularly through helping him examine and evaluate his beliefs and thoughts.

**Student Learning Objectives:**
- To understand the various biblical, historical, and social views of the self and human nature
- To comprehend the differences between modern developmental views of the self and biblical views
- To be able to explain the different SITs and spiritual disciplines that can be used in the counseling process to help the client move towards healthy development of the self and healthy spiritual growth

**Chapter Summary:**
In this chapter, Jones discusses various biblical, historical, and social views of the self and human nature, how they relate to the counseling field, and how counseling can facilitate development of the self and Christian spiritual growth.

According to the Bible, a biblical view of the self is based on the foundation of the self being made in the image of God and possessing a body, a spirit, and a soul. Original Hebrew thought views the self as a whole person possessing all three
aspects. Humans are seen as unique from other living beings because humans are made in God’s image, can communicate with him, and were chosen by God to be responsible for handling his creation. Additionally, the human self is not independent of the social context, with a need for community with God and others. The self has free will and the ability to choose, but the self is also fallen, and can make sinful choices solely in the interest of the self. The self also has the ability to regulate itself, and the Bible is replete with commands to cultivate self-control and discipline. We are repeatedly told to put off our old self, or destructive behaviors, and put on the new self, or healthy behaviors, as we grow and are transformed in Christ.

To describe a historical view of the self, Jones mentions Descartes, a seventeenth century philosopher who brought the self to the center of philosophical inquiry. Descartes postulated that God is not personally involved in human lives. Yet there were other philosophers that held the opposite view, such as Vande Kemp and Delitzsch, who both investigated biblical ideas relating to the self based on Scripture. Jonathan Langstaff Forster in particular emphasized the idea of taking a biblical view of the self and the soul in 1873, standing in contrast to other philosophers of his time who viewed the body and the soul as separate, unrelated, and opposite elements. Later, in 1912, Fletcher also emphasized this idea of biblical psychology and stated that the foundation of this view is God’s role in our original and current existence. Concerning biblical counseling, there are four historical elements, as suggested by Clebsch and Jackle in 1964: (1) healing, including physical aspects such as medication but also spiritual aspects; (2) sustaining, in which the counselor assists the client to endure and grow through suffering and difficulty; (3) guiding, in which wisdom and insight are provided; and (4) reconciling, in which the counselor helps the client to grow in relationship with God and others. Yet during this same time period, the 1960s, counseling and psychology began to focus on the self from a humanistic perspective. For example, Maslow’s hierarchy of needs placed self-actualization as the greatest need, rather than a need for God or for others. Additionally, Rogers created person-centered psychotherapy, in which the self’s own experience was considered the highest authority.

As previously mentioned, the self has been considered to not be independent from others, both biblically and from a secular perspective. Cooley (1902) coined the term “looking-glass self” to illustrate how the self is formed and seen through the responses of others. He divided self-development into three stages: (1) how we think others see our behaviors; (2) how we think others interpret our behaviors; (3) the feelings we have about ourselves based on the previous two stages. Similarly, Mead (1934) also believed that the self cannot develop apart from social interactions, and divides the self into two parts known as “I” and “me.” The “I” is
the raw material of the self, and the “me” is the part that is formed socially. The full self develops through interactions between the “me” and the “I.” Mead describes three developmental stages through which the self proceeds: (1) the imitative stage, involving imitating others; (2) the play stage, involving taking on the attitudes and behaviors of others; and (3) the game stage, where the “me” and the “I” come together and form the full self. Goffman (1959) provides another way of conceptualizing the self by comparing our lives to performing in a theater.

All these views of the self are helpful and insightful, although they do not address the relationship with our Creator in the process of self-development. Modern developmental theories of the self, according to Webb-Mitchell, possess the following five characteristics: (1) individualism; (2) opposition to authority; (3) the centrality of the mind; (4) natural religion, in which religion is considered a social construct; and (5) universalism. He also created a list of characteristics possessed by a biblical developmental theory of the self: (1) community and its story, (2) obedience to authority, (3) we are mind/body/spirit in Christ, (4) God in Christ, and (5) a particular people of a particular God: a kind of universal. Character-development and maturity in Christ are two other theories of self-development that contrast the modern developmental views, and are advocated by Fowers (2005) and Barna (2011).

Jones presents the case of Ben, who is having identity issues, particularly concerning his identity in Christ, and is having a midlife crisis of the self. According to Levinson (1978), there are four polarities involved in the midlife-crisis: (1) the young-old polarity, (2) the destruction-creation polarity, (3) the masculine-feminine polarity, and (4) the attachment-separateness polarity. Ben must work through these polarities, as well as working on his spiritual growth and identity development in Christ. Roberts (2001) suggests three steps that can be taken in counseling to assist in the spiritual growth process. The first step is to assess the personality of the believer. Then, clarify the gospel and teach therapeutic agency. Another counseling tool is to teach the client self-assessment skills and emotional honesty, which will help him to “put off” unhealthy behaviors and “put on” healthy ones. Some spiritual SITs that can help with Christian formation and development of the self include various prayers, such as prayers of thanksgiving; confession; seeking God’s blessing, peace, and protection; petition; intercession; asking God for words and opportunities to speak them; contemplation; and listening. Spiritual disciplines such as reading, meditation, suffering, community, worship, confession, forgiveness, godly actions, and many others can be helpful as well. If desired, one could separate the various disciplines into categories of cognitive and behavioral, or interpersonal, worship, and healing.

It can also be beneficial to help the client develop a godly attitude towards life and self, particularly through helping him examine and evaluate his beliefs and
thoughts. There are several approaches to changing thoughts and beliefs, including a six-step approach by McMinn and a five-step approach by Leaf. Garner proposed an approach of repetition to originally help musicians conquer stage fright, and Pearce lists seven steps that can be followed to help a client develop healthy thought patterns.

**Pedagogical Suggestions:**

- Have students write an essay or discussion board post describing their own biblical view of the self, using information from the text, the Bible, and other sources.
- Ask students to make a timeline and describe the historical and social views of the self discussed in the chapter. Ask them how they think these views compare to the current secular views of the self in our culture today, and what some of the reasons could be that people hold to these views.
- On page 207, Barna lists 10 stages of maturity in Christ. Ask students to have a class/group discussion or write a discussion board post on whether they agree or disagree with the list and why. If they disagree, ask them to create a list of their own stages of maturity in Christ.
- Ask students to break into pairs/triads and to create/present their own case study report or role play illustrating an issue of the self and strategies or theories discussed in the chapter. Make it a contest to see whose is most creative and educational.
- Have students list all the spiritual activities discussed in the text and discuss as a class or in groups how they could incorporate them into counseling with future clients, what issues they could be helpful for, etc. Ask students if they have ever used any of the activities/disciplines themselves and what their experiences were like.
- In the text, Leaf lists five steps to changing thoughts and behavior. Ask students to follow the steps over the course of 21 days (choosing a thought or behavior they would like to change but that is also small and not extremely serious) and write a short paper/discussion board post on their experience with the exercise and how they could use it to help future clients.

**Chapter 10 Quiz (25 questions):**

**Fill-in-the-blank**

1. __________________ shifted the focus of philosophy to the self and believed that God is not actively engaged in our lives. *(Descartes)*
2. In his person-centered therapy, ____________ replaced God with “personal experience” as the highest authority. (Rogers)
3. Cooley referred to our individual identity as the reflected or ______________: a self that develops through our perception of how others respond to our behavior. (looking-glass self)
4. ____________ believed that social interaction leads to the development of the self and divided the self into the “I” and the “me.” (Mead)
5. ______________, in his dramaturgical theory, likened our lives to performances in a theater. (Goffman)
6. ______________ is one of Webb-Mitchell’s five characteristics of modern developmental theories, and is the view that the individual is primary, existing for the self, without regard for God or others. (individualism)
7. ______________ proposed that character traits make it possible to pursue the good life, a concept also known as virtue ethics. (Fowers)
8. ______________ disciplines address disordered thought life and include meditation, listening, Scripture, study, prayer, and discernment. (cognitive)

True/False
1. According to a biblical view of the self, the self has freedom of choice. (T/F)
2. According to a biblical view of the self, the self is fallen and sinful. (T/F)
3. According to a biblical view of the self, the self has the capacity to self-regulate. (T/F)
4. “Experience a profound compassion and love for humanity” is listed as the final stage in Barna’s ten stages of maturity in Christ. (T/F)
5. The lost-found polarity is listed as one of Levinson’s four polarities affecting a midlife crisis. (T/F)
6. The destruction-creation polarity is listed as one of Levinson’s four polarities affecting a midlife crisis. (T/F)
7. Healing disciplines help repair and restore broken spiritual and interpersonal relationships. (T/F)
8. Gathering the thoughts and actions that you want to change and looking for the underlying motivations is the first step in Leaf’s five steps for changing thoughts and behavior. (T/F)
9. Giving back and saying thanks are listed by Pearce as practical treatment tools that can assist clients in challenging distorted thinking and developing healthy biblical thinking. (T/F)

Multiple Choice
1. According to the text, a biblical view of self involves:
   a) People have a body, soul, and spirit.
b) Humans reflect the image of God.
c) Humans have the unique ability to communicate with God.
d) Humans are tasked with responsibility for God’s creation.

**e) All of the above**

f) Only A through C
g) None of the above

2. Clebsch and Jaekle identified the following as historical functions of pastoral care and counseling:
   a) Healing
   b) Sustaining
   c) Guiding
   d) Reconciling
   e) Caring
   **f) All except E**
   g) All except B and C

3. Which of the following is NOT one of the stages in Cooley’s development of the self?
   a) We imagine or interpret how others judge our behavior/appearance.
   b) We imagine or observe how our behavior appears to others.
   c) We have self-feelings about the perceived judgements of others.
   d) Both A and C
   **e) None of the above**

4. Which of the following is NOT one of Mead’s three developmental stages of the self?
   a) The game stage
   b) The play stage
   c) The imitative stage
   **d) The mimicry stage**
   e) None of the above

5. ____________ is one of Webb-Mitchell’s five characteristics of modern developmental theories.
   a) Community and its story
   **b) The centrality of the mind**
   c) Obedience to authority
   d) We are mind/body/spirit in Christ
   e) None of the above

6. Which of the following is NOT one of Roberts’ three steps to counseling for transformation and soul growth?
   a) Assessing the personality of the believer
   **b) Clarifying the gospel**
c) Teaching therapeutic agency
d) **Teaching spiritual agency**
e) None of the above

7. Celebration and hospitality are examples of:
   a) **Worship disciplines**
   b) Interpersonal disciplines
   c) Healing disciplines
   d) Behavioral disciplines
   e) None of the above

8. Which of the following is one of McMinn’s six steps for challenging thoughts and beliefs?
   a) Help client dispute automatic thoughts
   b) Find underlying core beliefs
   c) Help client dispute core beliefs
   d) Help client maintain gains
   e) **All of the above**
   f) Only B and C
Key Terms: coping skills, cognitive appraisal, stress, hippocampus, adrenaline, cortisol, psychodynamic coping skills, cognitive coping skills, appraisal-focused coping, problem-focused coping, emotion-focused coping, deep breathing exercises, progressive muscle relaxation, guided imagery, psychological coping skills, intrapsychic coping skills, self-compassion, mindfulness, cognitive restructuring, pro-con lists, goal setting, interpersonal/social coping skills, interpersonal effectiveness skills, cultural rituals, religious coping, lament

Key Points:
- Coping skills aim at reducing, removing, or surviving emotional, physical, and psychological pain.
- The view one takes of one’s suffering is known as cognitive appraisal, which consists of two steps. In the first step, the individual labels the experience as good, bad, or challenging, and the second step involves deciding what to do about the newly labeled event.
- Research has shown that stress has a significant impact on the body, including faster breathing, tense muscles, higher blood pressure, and a release of adrenaline, noradrenaline, glucose, glutamate, and cortisol.
- Stress can also create difficulties in memory and new learning due to changes in the brain.
- Coping skills can also be divided into psychodynamic—focusing on ego strength development and relationships—and cognitive, which help with specific symptoms and emotional regulation.
- Coping can additionally be divided into adaptive and maladaptive, as well as appraisal-focused, problem-focused, emotion-focused strategies, physiological, psychological, interpersonal, and religious.
- Physiological coping, or physiological management, includes breathing exercises, progressive muscle relaxation, and guided imagery to calm the overactive nervous system.
- Psychological and intrapsychic coping skills focus on an individual’s internal experiences such as emotions and thoughts, and include self-
compassion, mindfulness, cognitive restructuring, pro-con lists, and goal setting.

- Interpersonal, or social, coping skills are beneficial because emotion regulation is significantly easier when one has someone trustworthy to help him, and include interpersonal effectiveness skills training and cultural rituals.
- Religious coping focuses on meaning-making and finding purpose in the midst of suffering, and is especially helpful when the suffering cannot be alleviated or lessened.
- Positive religious coping includes helping others, utilizing one’s faith community for support, believing that one’s higher power or God will use suffering for the strengthening of faith, and lament.

**Student Learning Objectives:**

- To understand the purpose and classifications of coping skills discussed in the chapter
- To be able to describe the misconceptions associated with suffering and the impact stress has on the body and brain
- To comprehend the various SITs associated with each category of coping skills

**Chapter Summary:**

Coping skills aim at reducing, removing, or surviving emotional, physical, and psychological pain. When reducing or removing the pain is not an option, meaning-making becomes paramount, searching for answers to the questions of “why, how, and what now” (p. 221).

The view one takes of one’s suffering is known as cognitive appraisal, which consists of two steps. In the first step, the individual labels the experience as good, bad, or challenging, and the second step involves deciding what to do about the newly labeled event. People generally view suffering as an unexpected experience, believing that suffering will not and should not happen to them. Another common misconception is that if God loved us, he would keep us from suffering, and therefore if we do suffer, God must not love us or must be punishing us for some reason. Scripture clearly contradicts all of these misconceptions, informing us that suffering is to be an expected part of life. However, these misconceptions, or appraisals, of suffering, create stress.

Research has shown that stress has a significant impact on the body, including faster breathing, tense muscles, higher blood pressure, and a release of adrenaline, noradrenaline, glucose, glutamate, and cortisol. Struggles with memory
and new learning can also occur as various changes in the hippocampus and grey matter in the brain take place. Certain enzymes are also released that can drive an individual to socially withdraw. These physiological phenomena are adaptive and helpful in life threatening situations. However, when not in a life-threatening situation, they are detrimental and cause distress. Clients typically come to counseling because these symptoms are occurring in the absence of a life-threatening event or after a life-threatening event has ended. In these situations, it can be best to begin with physiological coping skills, then move to cognitive, social, and religious ones.

In general, coping skills can also be divided into psychodynamic—focusing on ego strength development and relationships—and cognitive, which help with specific symptoms and emotional regulation. Coping can additionally be divided into adaptive and maladaptive, as well as appraisal-focused, problem-focused, and emotion-focused strategies. Appraisal-focused involves learning to think about the stressful situation in a different way that lessens the distress. Problem-focused involves focusing on healthy ways to influence or change the stressful situation, and emotion-focused involves learning ways to lessen or tolerate the emotions elicited by the stressful situation, typically used first when the situation appears to be out of the client’s influence or control. Emotion-focused is also known as secondary coping. Finally, coping skills can be divided into physiological, psychological, interpersonal, and religious.

Physiological coping, or physiological management, includes breathing exercises, progressive muscle relaxation, and guided imagery to calm the overactive nervous system. The most simple breathing exercise involves breathing in through the nose for two counts and breathing out through the mouth for four counts. When clients are resistant to learning physiological coping skills, educating them about the nervous system and normalizing their feelings of anxiety and awkwardness can be helpful.

Psychological and intrapsychic coping skills focus on an individual’s internal experiences such as emotions and thoughts, and include self-compassion, mindfulness, cognitive restructuring, pro-con lists, and goal setting. Self-compassion consists of treating oneself kindly, recognizing that one is an imperfect human just like everyone else, and learning to be in the present moment; from a Christian perspective, this can also include learning to give and receive grace. Mindfulness, also sometimes called grounding, involves learning to be aware of the present moment, and consists of asking oneself questions about the current moment relating to one’s senses. Cognitive restructuring involves recognizing errors in thinking and learning how to replace them with healthy thought patterns based on truth. This process begins with identifying the triggering situation or event, identifying the resulting emotions, and identifying the resulting thoughts.
Then, one looks for evidence to support or contradict the thoughts, and replaces the thoughts with healthy, more accurate alternatives. Pro-con lists and goal setting are fairly self-explanatory.

Interpersonal, or social, coping skills are beneficial because emotion regulation is significantly easier when one has someone trustworthy to help him. Enhancing relationship abilities through interpersonal effectiveness skill training can be helpful. According to Marsha Linehan, creator of dialectical behavioral therapy (DBT), the three types of interpersonal effectiveness in a social exchange are objective (the goal of the social exchange), relational (a relationship without conflict), and self-respect (the ability to say no, have boundaries, and other self-respecting relational abilities). Cultural rituals can also be considered as interpersonal coping skills.

Finally, religious coping focuses on meaning-making and finding purpose in the midst of suffering, and is especially helpful when the suffering cannot be alleviated or lessened. Positive religious coping includes helping others, utilizing one’s faith community for support, believing that one’s higher power or God will use suffering for the strengthening of faith, and lament. Helping clients to engage with God in the midst of their pain, lament is a powerful form of coping when one has no control over the suffering. A five-step process for lamenting, based on many of the biblical psalms, was created by Hall in 2016, and can be followed either formally or informally. In this process, one invites God’s presence into the suffering, expresses the pain, asks for his intervention, meditates on God’s character and why he should intervene, and then praises God for who he is as an expression of trust in him.

**Pedagogical Suggestions:**

- Ask students to describe the common beliefs/misconceptions people tend to have about suffering, including those mentioned in the text and any others they can think of. Ask them to articulate and analyze their own beliefs about suffering, and ask how they would go about assessing these types of beliefs in future clients. This can be done in a class discussion format, an essay format, or a discussion board post.

- Ask students to create a case study illustrating either appraisal-focused, problem-focused, or emotion focused coping skills. This can be done in a presentation format or a written format.

- Have students break into pairs or triads and practice teaching each other deep breathing and progressive muscle relaxation techniques, including psychoeducation on the nervous system and how these techniques are beneficial. If in triads, have the third person offer feedback.
• Assign students to practice the concept of self-compassion, or grace, described in the text over the course of one week; they can be creative in how they choose to apply this concept to their lives. Then, have them write a report or discussion board post on their experience and how they could potentially use this intervention with future clients.
• Have students break into pairs/triads and role-play imaginary scenarios of using/teaching cognitive restructuring in a counseling setting.
• Assign students to practice the goal-setting technique described in the chapter on themselves with a small, measurable, achievable goal. Have them write up a brief report or discussion board post on their application process and whether it was effective or not. Have them write about how this technique could be used with future clients.
• Ask students to research interpersonal effectiveness skills (in legitimate, peer reviewed, scholarly journals) and how to teach them in the counseling setting. Students may create presentations, brief papers, or discussion board posts to present their information.

Chapter 11 Quiz (25 questions):

Fill-in-the-blank
1. The __________ appraisal process occurs in two steps: primary appraisal and secondary appraisal. (cognitive)
2. The structure in the brain that can be affected by stress is the __________, resulting in struggles with learning and memory. (hippocampus)
3. Coping skills derive from two main schools of therapeutic intervention: __________ and cognitive behavioral approaches. (psychodynamic)
4. __________ coping involves changing how one thinks about a problem or stressor in order to reduce anxiety. (appraisal-focused)
5. __________ assists in minimizing the common “thinking errors” that occur when we cope by identifying and confronting these distortions. (cognitive restructuring)
6. __________ is the process of identifying, outlining, and pursuing steps to solve a problem. (goal-setting)
7. __________ coping attempts to better understand and create meaning during stress and suffering. (religious)
8. __________ provides a process for clients to engage with God in relationship, to increase their comfort with discomfort. (lament)
**True/False**

1. The misconceptions about suffering include the commonly held assumption that stress or the unexpected is “bad” and that “bad things won’t happen to me.” (T/F)
2. Stress can activate certain enzymes that literally result in individuals being less social, avoiding their peers, and having increased difficulty in comprehension and memory. (T/F)
3. Some research has shown that mindfulness is as effective as taking medication to prevent relapse of major depression symptoms. (T/F)
4. Cultural rituals are mentioned as a type of religious coping. (T/F)
5. Positive religious coping includes believing that God or one’s higher power will use the experience to strengthen one’s faith. (T/F)
6. Volunteerism and charity are NOT examples of positive religious coping. (T/F)
7. Interpersonal effectiveness skills are used to create and attend to healthy relationships, which include any skill or behavior that improves our social interactions. (T/F)
8. Identifying potential obstacles is NOT a part of the goal-setting process. (T/F)
9. One limitation to cognitive restructuring is that acute emotional discomfort can interfere with activating the higher order thinking that it requires. (T/F)

**Multiple Choice**

1. The process in which an event is labeled as good/beneficial, a challenge, or a threat of possible harm is known as:
   a) Secondary appraisal  
   b) **Primary appraisal**  
   c) Psychological coping  
   d) Problem-focused coping  
   e) None of the above

2. Which of the following is NOT a physiological effect of stress?
   a) A release of glucose  
   b) A release of glutamate  
   c) A release of noradrenaline  
   d) Slowed digestion  
   e) All of the above  
   f) **None of the above**

3. The four categories of coping set forth by Pargament do NOT include:
   a) Interpersonal  
   b) **Psychodynamic**
c) Physiological
d) Psychological
e) Religious
f) None of the above

4. In the basic breathing exercise to calm the nervous system, one should breathe in for two counts and breathe out for ___________ counts.
a) Two
b) Three
c) **Four**
d) Five
e) Two and a half

5. Self-compassion involves all of the following EXCEPT:
a) Self-kindness
b) Mindfulness
c) Common humanity
d) **Self-awareness**
e) None of the above

6. Pro-con lists, while helpful, can often fall victim to common cognitive distortions or errors of thinking, such as:
a) Mental filters
b) Emotional reasoning
c) Should statements
d) Overpersonalizing
e) All-or-nothing thinking
f) All of the above
g) **Only A through C**

7. The types of effectiveness within an interpersonal exchange as described by Linehan include all of the following EXCEPT:
a) Objective
b) Relational
c) **Intrapsychic**
d) Self-respect
e) None of the above

8. All of the following are stages in Hall’s lament process EXCEPT:
a) Confidence in God
b) Complaints
c) Request
d) Motivation
e) **Expression**
f) Address to God
g) None of the above
Chapter 12
Attachment-Oriented Strategies by Gary Sibcy, PhD

Key Terms: secure base, the SECURE model, the secure base system, attachment style, the attachment system, the exploration system, internal working model (IWM), secure attachment, avoidant attachment, preoccupied attachment, fearful-avoidant attachment, Bowlby, James McCullough, Siegel, therapeutic attunement, attachment-informed counseling, significant other history, transference hypothesis, interpersonal situation analysis, discipline personal involvement, interpersonal discrimination exercises, interpersonal neurobiology, narrative strategies

Key Points:

• God is a relational God, he created us as relational beings, and his transcendence and immanence provide an unfailing secure base system for us.

• The secure base system, or SECURE model, is comprised of the exploration system and the attachment system; the exploration system is activated when one feels secure, and the attachment system is activated when one feels threatened.

• Over time, a child’s secure base system becomes the filter through which he views himself and others, and is known as his internal working model (IWM).

• There are four different types of attachment: secure, avoidant, preoccupied, and fearful-avoidant.

• The Bible is replete with examples that illustrate these relational patterns, and it is important to be aware of them as we engage with our clients, especially of the ways in which Jesus is described as the ultimate secure base for us.

• It is important to remember that not all pathology can be attributed to attachment styles.

• Individuals with an avoidant attachment style tend to struggle with perfectionism and a fear of failure, as well as a poor ability to tolerate negative emotions. They often engage in both experiential and relational avoidance.

• Those with a preoccupied attachment style tend to focus on relational issues such as abandonment or rejection. Preoccupied individuals also struggle
with emotionally driven behaviors, behaviors that are exhibited in response to negative affective experiences, such as compulsions.

- Those with a fearful-avoidant attachment style utilize both avoidant and preoccupied features, longing for intimacy but engaging in relational avoidance. They also fear abandonment and rejection, and are most likely to engage in tension reduction behaviors such as cutting and purging.

- The best way for the counselor to connect with the client for the purposes of influencing attachment is by targeting the right hemisphere of the brain, as this is where attachment models are thought to be stored.

- Sibcy (2018) describes the SECURE model, built on past research by Bowlby, in which there are six tasks of attachment-informed counseling: safety, education, containment, understanding, restructuring, and engagement.

- Other methods for attachment-informed counseling, developed by James McCullough, include significant other history, transference hypothesis (a hypothesis on how the client could be transferring past attachment patterns onto the counselor), interpersonal situation analysis, discipline personal involvement, and interpersonal discrimination exercises.

- Another attachment-informed method is known as interpersonal neurobiology (IPNB), which is based on the work of Siegel and focuses on the relationship between the mind/brain and one’s relationships.

- Narrative strategies can help the client learn to both tell and reframe his story while learning how to self-soothe and grow from negative experiences.

Student Learning Objectives:

- To be able to describe the biblical examples of attachment mentioned in the chapter and the ways in which God provides himself as a secure base

- To understand the four different attachment styles, associated tendencies for pathology, and associated models such as the SECURE model and IWMs

- To comprehend the various methods described in the chapter for attachment-informed counseling

Chapter Summary:

Attachment theory, a meta-theory that provides a lens through which to view and understand other types of counseling theories, reflects God’s design for humans to be completely dependent upon other humans when they are first born into the world. God is a relational God, he created us as relational beings, and his transcendence and immanence provide an unfailing secure base system for us.
The secure base system, or SECURE model, is comprised of the exploration system and the attachment system; the exploration system is activated when one feels secure, and the attachment system is activated when one feels threatened. Both systems cannot be active at the same time. Over time, a child’s secure base system becomes the filter through which he views himself and others, and is known as his internal working model (IWM). Attachment is considered to be generally stable across a person’s lifetime, and can be compared to a physical immune system in terms of how it is believed to affect one’s psychological health.

There are four different types of attachment: secure, avoidant, preoccupied, and fearful-avoidant. In secure attachment, a child believes he is capable and worthy of love, and others are also capable and can be counted on to meet his needs; in other words, he has a positive view of himself and others, and can move easily between the attachment and exploration systems. As an adult, he is comfortable with both intimacy and independence. A child with an avoidant attachment style has a positive view of himself but a negative view of others. He is not able to operate well out of his attachment system, and instead operates out of excessive exploration. This usually develops as parents are emotionally unresponsive when the child seeks security and instead emphasize independence, even when the child is very young. As an adult, the individual may struggle with intimacy. In preoccupied attachment, the child has a negative view of himself but a positive view of others. Typically this develops as parents discourage or prevent the child from using his exploration system, are unreliable about meeting the child’s needs, and can sometimes even rely on the child to meet their own needs. Individuals with this attachment style may have difficulty feeling relief or love from others even when others are responsive to them, and they may also feel that their emotions must be intense in order to get others to respond. Finally, a child with a fearful-avoidant attachment style has a negative view of both self and others, and often occurs when parents are abusive. The child is dependent on the parent to meet his needs, but the parent is also causing the child pain. In response, the child may learn to dissociate, and as an adult may struggle with both intimacy and independence. These individuals may also be drawn to relationships that repeat this abusive dynamic.

The Bible is replete with examples that illustrate these relational patterns, and it is important to be aware of them as we engage with our clients, especially of the ways in which Jesus is described as the ultimate secure base for us. Jesus urges those who are in pain and in need to come to him for comfort and safety. He also encourages the exploration system by telling us to “go and make disciples” in Matthew 28:18-30, reassuring that his presence will always be with us as a secure base. Additionally, Paul writes in Philippians 4:4-7 that God is always near to us, and that when we feel anxious or fearful, we can turn to him through prayer and
find safety. Attachment patterns are also illustrated in the Old Testament, with King Saul exhibiting a preoccupied attachment style and David displaying a secure style, feeling confident in God’s love for him.

Concerning the counseling context, it is first necessary to note that not all pathology can be attributed to attachment styles, as there are myriad other factors involved. Research suggests that temperamental traits of neuroticism, negative affectivity, inhibition, and avoidance also play a role, as well as environmental factors, general and specific psychological vulnerabilities. However, there are several ways in which attachment does influence pathology, and there are several ways in which this knowledge could be useful for the counselor.

Individuals with an avoidant attachment style tend to struggle with perfectionism and a fear of failure, as well as a poor ability to tolerate negative emotions. They tend to engage in both experiential and relational avoidance, meaning that they attempt to avoid any negative affective experience and any opportunity to let another person know about said experience, respectively. Such avoidance is a known factor in depressive and anxiety disorders. Similarly, those with a preoccupied attachment style also engage in experiential avoidance, although rather than being concerned with self-related issues such as perfectionism, they tend to focus on relational issues such as abandonment or rejection. Preoccupied individuals also struggle with emotionally driven behaviors, behaviors that are exhibited in response to negative affective experiences, such as compulsions. Finally, those with a fearful-avoidant attachment style utilize both avoidant and preoccupied features, longing for intimacy but engaging in relational avoidance. They also fear abandonment and rejection, and are most likely to engage in tension reduction behaviors such as cutting and purging.

Because attachment style does influence pathology, therapeutic attunement is critical. The best way for the counselor to connect with the client for the purposes of influencing attachment is by targeting the right hemisphere of the brain, as this is where attachment models are thought to be stored. The counselor’s own emotions, expressions, eye contact, and body language are essential in conveying empathy and connecting with the client, especially when the client is experiencing intense or negative emotions. Additionally, Sibcy (2018) describes the SECURE model, built on past research by Bowlby, in which there are six tasks of attachment-informed counseling: safety, education, containment, understanding, restructuring, and engagement. Safety involves helping the client develop a sense of hope, as well as helping him explore his reason for coming to counseling, his past history, and current goals. Education involves helping the client understand his problems or situations and developing skills to cope with them, such as spiritual formation skills. With containment, the counselor must find the balance between challenging and supporting the client, or the therapeutic window, and with
understanding the counselor helps the client understand how his past relationships may be affecting his present, possibly through attachment assessment measures. Finally, restructuring helps clients to see their lives and problems in new ways, also known as schema reconstruction.

Other methods for attachment-informed counseling, developed by James McCullough, include significant other history, transference hypothesis (a hypothesis on how the client could be transferring past attachment patterns onto the counselor), interpersonal situation analysis, discipline personal involvement, and interpersonal discrimination exercises. The interpersonal discrimination exercises help a client to recognize how her current relational experiences, perhaps with the counselor, are different from the negative ones in his past. Interpersonal situation analysis is a method of examining a current situation in the client’s life to help the client first become aware of his behavior and its effects and then to find a way to change his behavior in a way that is more conducive to achieving his desired outcomes. Another attachment-informed method is known as interpersonal neurobiology (IPNB), which is based on the work of Siegel and focuses on the relationship between the mind/brain and one’s relationships. It can be helpful for clients to understand how their physical brain impacts and is impacted by their relationships throughout their lives. Furthermore, narrative strategies can also be employed in the counseling process to help the client learn to both tell and reframe his story while learning how to self-soothe and grow from negative experiences.

Pedagogical Suggestions:

- Using the examples and verses listed in the text as well as the Bible and/or other sources, have students discuss or write a discussion board post on all the specific ways they can think of that God/Jesus provides a secure base for us. Ask how this information could be used directly or indirectly in a counseling setting, both Christian and secular.
- Ask students to independently research “God attachment” using scholarly, peer-reviewed journals and write up a report, discussion board post, paper, or PowerPoint presentation to reveal their findings. Ask how this information could be used in future counseling.
- The chapter discusses both experiential avoidance and relational avoidance. Ask students to discuss as a class or in groups ways in which these issues could be addressed for future clients in counseling.
- Have students break into pairs or triads and practice role-playing each attachment style in a counseling setting. Have the “counselor” or the observer try to guess the “client’s” attachment style, and have the “client” try to make it difficult for them to guess while still being true to the style.
• Have each student write up a brief report on a hypothetical client with one of the attachment styles, trying to make it difficult to guess but also being true to the style, and have their classmates guess the style as they present their report. This can be done in pairs or triads as well for the sake of time.
• Have students break into pairs or triads and practice conducting a significant other history, then forming a transference hypothesis based on one of the four types mentioned in the text. Students can take turns role-playing an imaginary client.
• Have students break into pairs or triads and practice an interpersonal situation analysis, taking turns role-playing counselor and client. Before beginning the exercise, have them summarize in their own words or list the seven steps involved on an index card or piece of paper that they can reference throughout the role-play, as well as any questions they may want to remember to ask the client. Students may also write a hypothetical role-play illustrating this technique as homework.
• Ask students to research interpersonal neurobiology as homework and write up a report, paper, discussion board post, or PowerPoint presentation on their findings and specific ways that this field can be helpful to their future counseling work, particularly in relation to attachment. Ask for details and practical ideas.
• Similarly, have students research narrative strategies as homework and write up a report, paper, discussion board post, or PowerPoint presentation on their findings and specific ways that these strategies could be helpful for counseling, particularly in relation to attachment.

Chapter 12 Quiz (25 questions):

Fill-in-the-blank
1. Attachment theory is a ____________ theory, which is a theory that helps us make sense of other theories. (meta)
2. When parents push their children to become independent and autonomous even when the children do not feel a sense of security, the children would be most likely to develop ________________ attachment style. (avoidant)
3. Attachment security is equated to emotional and psychological health like the body’s _________________ is to our physical health. (immune system)
4. Those with ________________ attachment style tend to be concerned about problems centering on self-definition such as perfectionism and fear of failure. (avoidant)
5. ________________ involves the person actively attempting to push out of their awareness negative thoughts, feelings, and images related to stressful life events. (**experiential avoidance**)

6. ________________ behaviors are extreme forms of emotionally driven behaviors and include cutting, burning, binging, purging, extreme forms of sexual acting out, and excessive drug and alcohol use. (**tension-reduction**)

7. The ________________ phase of the SECURE model involves finding the therapeutic window, or the balance between supporting and challenging. (**containment**)

8. ________________ is a field that studies the interaction between relational experiences and the developing mind. (**interpersonal neurobiology**)

**True/False**

1. In the SECURE model, the exploration system and the attachment system can both be operating at the same time. (T/F)
2. For those with an avoidant attachment style, the attachment system is underactivated and the exploration system is overactivated. (T/F)
3. In the Bible, David is an example of having a preoccupied attachment style with God. (T/F)
4. Attachment is considered relatively stable across the lifespan. (T/F)
5. Those with a preoccupied attachment style tend to get flooded by and entangled in their internal experiences. (T/F)
6. Therapeutic relationships are best established by targeting a client’s left hemisphere of the brain. (T/F)
7. The restructuring phase of the SECURE model involves helping clients develop coherent narratives that help them make sense of their existence in light of God’s redemptive story in their lives, also known as schema reconstruction. (T/F)
8. Interpersonal situation analysis helps clients understand how they handle relationship conflict. (T/F)
9. Narrative strategies in attachment therapy can help clients learn to self-soothe and to reframe their stories. (T/F)

**Multiple Choice**

1. When the secure based system is internalized by the individual, it is known as the ________________.
   a) **Internal working model** (IWM)
   b) External working model (EWM)
   c) SECURE model
   d) Schema
2. The following statement is an example of ______________ attachment: I’m not worthy of love, and I desperately need others to take care of me, but I must be in great need in order for her to respond to my emotions.
   a) Secure
   b) Avoidant
   c) **Preoccupied**
   d) Fearful-avoidant
   e) None of the above

3. Which attachment style is thought to be the “genesis of dissociation”?
   a) Secure
   b) Avoidant
   c) Preoccupied
   d) **Fearful-avoidant**
   e) None of the above

4. Known factors other than attachment style involved in psychological pathology include:
   a) Temperament traits such as neuroticism
   b) Environmental risks
   c) General psychological vulnerability
   d) Specific psychological vulnerability
   e) **All of the above**
   f) Only A through C
   g) None of the above

5. Individuals with ______________ attachment style desperately long to merge themselves with another person while at the same time employing avoidance strategies to keep others at a distance.
   a) Secure
   b) Avoidant
   c) Preoccupied
   d) **Fearful-avoidant**
   e) None of the above

6. Which of the following is NOT one of Sibcy’s six tasks of the SECURE model?
   a) Safety
   b) Education
   c) Containment
   d) Understanding
   e) **Assessment**
   f) None of the above
7. Transference hypothesis and interpersonal situation analysis are strategies from _________________’s model of therapy that can be used in attachment-informed counseling.
   a) Bowlby
   b) Sibcy
   c) McCullough
   d) Siegel
   e) Cindy
   f) None of the above

8. ___________________ help(s) clients differentiate past toxic relationships from the present therapeutic relationship through asking the client a series of questions.
   a) Significant other history
   b) Interpersonal situation analysis
   c) Interpersonal discrimination exercises
   d) Transference hypothesis
   e) None of the above
Chapter 13
*Child-focused Strategies* by Kevin B. Hull, PhD

**Key Terms:** Self-awareness, self-agency, self-continuity, Harter, safety, active listening, confidentiality, play therapy, sand tray therapy, computer/video/tablet games, Gestalt, Perls, “I” language, empty chair technique, two chair technique, Adler, individual psychology, systematic desensitization, cognitive therapy, rational-emotive behavioral therapy (REBT), cognitive behavioral therapy (CBT), solution focused brief therapy (SFBT)

**Key Points:**
- Self-awareness, self-agency, and self-continuity are three main categories of childhood self-development identified by Harter in 2012.
- When establishing a therapeutic relationship with a child client, it is important to focus on safety, active listening, identifying the problem, and confidentiality.
- Play therapy is especially helpful for children, as play is said to be the main way in which children express and make sense of their world. Sand tray therapy, one aspect of play therapy, is helpful for similar reasons, and involves a sand tray, miniatures, and access to water so that the child can create whatever she wishes in her tray of sand.
- Computer games, video games, and tablet games can be used to help the child bond with the counselor through mutual play or to provide analogies for various life situations, as many games involve conflict and themes of overcoming, relying on others for help, and improving or growing.
- Other SITs that can be useful with children include Gestalt techniques such as “using I-language, substituting ‘won’t’ for ‘can’t’, taking responsibility, and . . . . the empty chair technique” (Hull, 2018, p. 278).
- Individual psychology also contributes several SITs to child therapy, based on Adler’s idea that negative behaviors have four possible goals: attention, power, revenge, and inadequacy.
- Understanding the child’s motives behind their negative behavior patterns is critical, as it allows the counselor and parents/caregivers to create reward systems that are most beneficial and help the child feel in control of herself.
- Systematic desensitization techniques can be helpful with fear and anxiety.
• Techniques from cognitive therapy, rational emotive behavioral therapy (REBT), and cognitive behavioral therapy (CBT) have also been shown in the research to be helpful.
• Solution-focused brief therapy (SFBT) helps children to create new ways of thinking and addressing problems through techniques such as the miracle question, scaling, reinforcement, and identifying exceptions.
• One particular issue that often brings children to counseling is the issue of loss, grief, or trauma. Children can have difficulty processing negative emotions and can interpret these emotions as negative reflections of themselves due to their ego-centric view of the world.

Student Learning Objectives:
• To be able to describe the unique developmental challenges faced by children (and those counseling them) and what the Bible says about children and their value
• To comprehend the ways in which a solid therapeutic relationship can be developed with a child client in a counseling setting
• To understand the various SITs that can be helpful with children and the particular issues with which they work well

Chapter Summary:
Children are a unique population, dependent upon others to meet their basic needs and constantly immersed in developmental growth and challenges. Self-awareness, self-agency, and self-continuity are three main categories of childhood self-development identified by Harter in 2012. The Bible is also descriptive of the developmental process, discussing the importance of nurturing, training, and valuing children. Furthermore, it provides examples of what happens when children are not nurtured, trained, or valued, or become wayward for other reasons, such as Eli’s sons, David’s son Absalom, or King Ahaz. Yet there is also the story of the prodigal son, which provides an illustration of hope and restoration.

When establishing a therapeutic relationship with a child client, it is important to focus on safety, active listening, identifying the problem, and confidentiality. For the child to feel a sense of safety, she must feel that both the counselor and the counseling room are safe. Physically getting on the child’s level, eye contact, clear explanations, and a calm voice are essential. Having child-sized furniture, open spaces, and toys can also help the child feel comfortable in the environment. Active listening involves open-ended questions, paraphrasing, summarizing, and verbal and nonverbal encouragement to help the child feel heard and understood. It is helpful to identify the current problem, or reason for
counseling, from the perspective of both the parent/caregiver and the child, and to identify what has been done to address the problem so far. With confidentiality, custody situations can be difficult, and it is always best to obtain permission from both parents before proceeding with counseling for the child. Asking the parents to waive their confidentiality rights, within the usual limits of course, can be helpful towards establishing trust in the child’s therapeutic relationship with the counselor.

Children often struggle with self-related issues due to their developmental journey such as shame, guilt, control, and autonomy, and there are a variety of therapeutic approaches that can be beneficial for them. Play therapy is especially helpful for children, as play is said to be the main way in which children express and make sense of their world. Sand tray therapy, one aspect of play therapy, is helpful for similar reasons, and involves a sand tray, miniatures, and access to water so that the child can create whatever she wishes in her tray of sand. Computer games, video games, and tablet games can also be helpful, as many children are familiar with and fond of them. They can be used to help the child bond with the counselor through mutual play or to provide analogies for various life situations, as many games involve conflict and themes of overcoming, relying on others for help, and improving or growing.

Other SITs that can be useful with children include Gestalt techniques such as “using I-language, substituting ‘won’t’ for ‘can’t’, taking responsibility, and . . . the empty chair technique” (Hull, 2018, p. 278). Similar to the empty chair technique, the two-chair technique can be used, in which the child acts out both parts while moving from chair to chair. Puppets or stuffed animals can also be used for this technique. Gestalt techniques for children line up very well with Scripture, as the Bible also supports taking responsibility and changing negative thought patterns through renewal of the mind.

Individual psychology also contributes several SITs to child therapy, based on Adler’s idea that negative behaviors have four possible goals: attention, power, revenge, and inadequacy. The encouragement technique involves accepting the child for who she is and encouraging her efforts, and the logical consequences technique involves helping her experience and understand how her actions have natural consequences. Adlerian play therapy can also help children develop a healthier sense of self, for example, using miniatures or puppets to reenact times when she was able to help others or times when others were there for her.

For more specific problems, behavioral approaches tend to work well for children as well as for the parents or caregivers, involving rewards/punishments and token economies. Understanding the child’s motives behind their negative behavior patterns is critical, as it allows the counselor and parents/caregivers to create reward systems that are most beneficial and help the child feel in control of herself. Systematic desensitization techniques can be helpful with fear and anxiety.
Techniques from cognitive therapy, rational emotive behavioral therapy (REBT), and cognitive behavioral therapy (CBT) have also been shown in the research to be helpful. Scripture verses and memorization can be useful with Christian children to help them learn basic CBT skills and learn how to identify “truth.” When time is limited, solution-focused brief therapy (SFBT) is an excellent option, based on the idea that poorly defined goals are the main reason for problems. SFBT helps children to create new ways of thinking and addressing problems through techniques such as the miracle question, scaling, reinforcement, and identifying exceptions. Art, sand trays, and other play therapy modalities can be used with SFBT as well.

Finally, one particular issue that often brings children to counseling is the issue of loss, grief, or trauma. Children can have difficulty processing negative emotions and can interpret these emotions as negative reflections of themselves due to their ego-centric view of the world. Therapy can be helpful in such processing and learning to view their situations differently, creating a healthier view of self as well. Play therapy can be used to address these difficult issues, and prescriptive play therapy is a beneficial option in which the counselor chooses certain toys or materials based on the particular loss or trauma experienced by the child. Scriptures and Bible stories can be woven in to the process for Christian children through art, writing, story-telling, or any other creative avenue.

**Pedagogical Suggestions:**

- Using not only the verses and information mentioned in the text but also others, have students research the topic of children in the Bible and write a discussion board post, brief and creative PowerPoint presentation, or brief report on their findings and how this information should impact their future counseling work.
- Have students break into pairs or triads and role-play one of the case studies (and associated SITs) mentioned in the text to practice the techniques.
- Have students break into pairs or triads and write down the elements of active listening on a piece of paper or index card. Then, have them practice it on each other while the other person tells a story from their childhood as if they themselves were a child. Have the third person, if in triads, be an observer to make sure the “counselor” utilized all the elements of active listening effectively.
- Bring in trays, sand, miniatures, and water (if possible) and have students practice being creative with sand tray therapy. They may construct their own sand tray worlds, either freely or in response to various prompts, or break into pairs and role-play with one person playing a child client.
• Bring in (or have students bring in) various art supplies such as papers, colored pencils, crayons, markers, stencils, clay, play-doh, etc. Assign students to role-play a child struggling with a particular problem or situation while another student practices using the art materials as a counselor. Students may also experiment and be creative with the materials themselves, responding to an issue/situation in their own lives, and can then share in groups or with the class (or write a discussion board post or report later) on their experience, what they learned, and how they could use art and creativity in future counseling with children.

• Alternatively, ask students to create their own art project as homework using any creative materials they desire, responding to an issue/situation in their own lives, and then present their work to the class along with a report on how the activity affected them and how such activities could be used in future counseling.

• Bring in a few puppets or stuffed animals, and have students break into pairs/triads to role-play a variation of the empty-chair or two-chair technique. One student will role-play a child client and one will role-play the counselor. Encourage creativity while getting students used to using these props with hypothetical child clients.

• In pairs/triads, have one student role-play a child with negative self-beliefs and an external locus of control. Have another student role-play the counselor, and use CBT techniques and even Scripture (incorporated in a creative way that a child would understand and enjoy) to help the child. The observer could offer suggestions if the counselor gets stuck at any point, and can also offer feedback. You can also role-play this as an example for the class, with one of the students role-playing the child client and you as the counselor.

• Have students break into pairs/triads and role-play to practice solution focused brief therapy with a hypothetical child client. They may write down the elements of SFBT on a card or paper to use as a guide.

• The text discusses at length the ways in which each type of therapy is compatible/incompatible with Scripture and a biblical worldview. Divide students into groups and assign each group a therapy or theory from the text, then have them create a brief presentation to teach the class how their assigned theory/therapy is compatible or incompatible with Scripture/Christianity. Ask them to include the information provided in the text but to also add original thoughts/verses/research of their own. Have them make it their goal to construct the most creative, entertaining presentation possible, and have the class vote on the best one.
Chapter 13 Quiz (25 questions):

Fill-in-the-blank
1. Open-ended questions, paraphrasing, summarizing, and verbal and nonverbal encouragement are all aspects of _______________. (active listening)
2. Parents can waive their confidentiality rights through ______________, a rule that allows the therapist to ensure that the regular restrictions to confidentiality will be observed, to help their children fully bond with the therapist and embrace the therapeutic process as theirs alone. (HIPPA)
3. “I” language, substituting “won’t” for “can’t,” and taking responsibility are all examples of ______________ therapy. (Gestalt)
4. The __________ technique is a back-and-forth process in which the child acts one part and then moves to another chair to act out what another part or person may say or do. (two-chair)
5. ________________ is based on the basic idea that the main problem usually stems from poorly defined goals. (solution focused brief therapy)
6. ________________ is the sense of having control over one’s thoughts and actions, and is critical as the child develops the idea that his behaviors impact others and situations around him. (self-agency)
7. The parable of _______________ in the Bible is an example to provide parents of wayward children with hope. (the prodigal son)
8. ________________ is credited with developing Gestalt therapy. (Fritz Perls)
9. Rewards/punishments, consequences, and a token economy are all techniques associated with the ____________ approach. (behavioral)

True/False
1. The two key elements of safety for the child in the counseling process are the therapist as a safe presence and the counseling room as a safe place. (T/F)
2. According to the text, children may struggle with shame, guilt, control, and autonomy, typical issues of self-representation that arise during their development. (T/F)
3. Play therapy is not compatible with Christianity. (T/F)
4. The individual psychology technique of unconditional affirmation involves accepting the child as she is and noticing her effort as opposed to the outcome. (T/F)
5. A behavioral approach to counseling children is inconsistent with Scripture. (T/F)

6. It is important to understand the child’s motives in order to create an effective reward/consequence system and help her feel that she can control herself. (T/F)

7. CBT has been shown to be particularly effective in helping children with depression. (T/F)

8. Solution focused brief therapy is effective but not compatible with expressive forms of play therapy such as art and the sand tray. (T/F)

Multiple Choice

1. The three categories of child self-development identified by Harter include all of the following except:
   a) Self-continuity
   b) Self-agency
   c) **Self-congruency**
   d) Self-awareness
   e) None of the above

2. When creating a therapeutic relationship with a child client, all of the following are listed as essential techniques except:
   a) Establishing a sense of safety
   b) Active listening
   c) Confidentiality
   d) Identifying the problem
   e) **None of the above**

3. Elements of sand tray therapy must include all of the following except:
   a) A tray of sand
   b) Water
   c) A collection of miniatures
   d) **Paper and pencils**
   e) None of the above

4. Individual psychology identifies which of the following as one of the four goals of misbehavior?
   a) Inadequacy
   b) Attention
   c) Revenge
   d) Power
   e) **All of the above**
   f) None of the above
5. When dealing with a child who struggles with fear and anxiety about a particular issue, such as going to school, the text suggests that __________ could be helpful.
   a) **Systematic desensitization**
   b) Emotion-focused trauma therapy
   c) Gestalt techniques
   d) Individual psychology
   e) None of the above
   f) All of the above

6. Solution focused brief therapy (SFBT) includes all of the following techniques except:
   a) Scaling
   b) The miracle question
   c) Identifying exceptions
   d) **Assessing attachment style**
   e) None of the above

7. The “wow and how” technique, part of solution focused brief therapy (SFBT), was developed by:
   a) Nims
   b) Homeyer
   c) Adler
   d) Perls
   e) None of the above

8. ____________ is a technique in which the therapist constructs a play environment to deal with a specific type of loss, strategically offering toys that will be suited for the child’s specific situation.
   a) **Prescriptive play therapy**
   b) Descriptive play therapy
   c) Artistic play therapy
   d) Creative play therapy
   e) None of the above
Chapter 14
Adolescent-focused Strategies by Andi J. Thacker, PhD

Key Terms: adolescence, differentiation, identity, prefrontal cortex, dopamine, creativity, unconditional positive regard, grace, patience, parental consent, parent consultations, developmental history, confidentiality, creative expression, choice giving, contract setting, activity therapy, open-ended questions, metaphor, feeling felt

Key Points:
- Adolescents face many developmental challenges such as differentiation, identity formation, peer connections, physiological changes in the brain, and the emergence of puberty and sexual identities/attractions.
- God created us with the ability to make choices and have a sense of agency, and the stage of adolescence is a strong reminder of those abilities.
- When seeking to establish a therapeutic relationship with an adolescent client, it is imperative that we present with unconditional positive regard, or grace, patience, and attentive listening skills, as adolescents usually do not choose to come to counseling voluntarily.
- It is recommended to conduct the first session with the parents only, obtaining this written consent as well as a developmental history of the client, and providing the parents with a chance to talk with the counselor about the problems and their expectations.
- Consultations with the parents can be held after every three or four sessions, and including the adolescent in these consultations is recommended to help foster trust in the therapeutic relationship.
- Sometimes it is helpful to provide parents with education and parenting tools that they could use as options to help them with their adolescent child, such as choice giving and contract setting.
- Similar to play therapy for children, activity therapy makes use of metaphors, symbols, and a wide variety of craft supplies or expressive activities such as pencils, paper, markers, photography, and music.
• Concerning the structure of the actual sessions, Thacker (2018) recommends “to allot five minutes for instruction about the activity, twenty to twenty-five minutes for the activity, and ten to fifteen minutes for processing” (p. 301).

**Student Learning Objectives:**

• To be able to describe the various challenges faced by adolescents and the best ways to establish a therapeutic relationship with them
• To understand the intricacies of adolescent therapy, including parental involvement, legal concerns, confidentiality, group therapy options, and session structure
• To comprehend the nature of activity therapy, the benefits of creative expression, and the role of the counselor in using this method

**Chapter Summary:**

God created us with the ability to make choices and have a sense of agency, and the stage of adolescence is a strong reminder of those abilities. Adolescents ages thirteen to eighteen are learning to make decisions for themselves, to forge strong connections with their peers, and to differentiate from their parents while still remaining connected in some ways. To use Erikson’s language, they are facing the challenge of identity versus identity confusion, trying to figure out who they are, and connections with their peers are especially important for navigating this challenge successfully. Additionally, their prefrontal cortex is developing, and their brain is experiencing a lower level of baseline dopamine, prompting them to engage in novelty-seeking behaviors to increase the levels. They tend to focus on the positive possibilities of risk-taking rather than the negative ones, and they are also experiencing the physical changes of puberty and developing sexual identities and attractions. It is therefore helpful to keep their developmental struggles and needs for peer connection in mind when entering into a counseling relationship with adolescents.

When seeking to establish a therapeutic relationship with an adolescent client, it is imperative that we present with unconditional positive regard, or grace. Adolescents usually do not choose to come to counseling, so it is important to be patient and move at the client’s pace. Listening well is essential, reflecting both content and feeling, and helping the client to feel that you truly understand her. Parents or caregivers are also a part of the counseling process, although they may not be in the actual sessions with their adolescent child, and the counselor must establish strong communication with them as well. Adolescents are considered minors, and most states require written parental consent for minors to receive counseling. Research and seek advice about legal considerations, especially when
blended families or custody disputes are present. It is recommended to conduct the first session with the parents only, obtaining this written consent as well as a developmental history of the client, and providing the parents with a chance to talk with the counselor about the problems and their expectations. Consultations with the parents can be held after every three or four sessions, and including the adolescent in these consultations is recommended to help foster trust in the therapeutic relationship. In situations where the adolescent does not share her parents’ faith values, it is wise to let her alone lead any discussions of spirituality, although the counselor can assure the parents that he will implicitly counsel from his Christian worldview.

Sometimes it is helpful to provide parents with education and parenting tools that they could use as options to help them with their adolescent child, always being respectful of their thoughts and feelings as parents. One such tool is choice giving, in which parents provide the adolescent with opportunities to make their own decisions, helping them learn to make wise choices and exercise their autonomy in a responsible way. Adolescents can also be given the opportunity to have a voice in their own disciplinary process, helping them learn how their choices have consequences and desire to take personal responsibility for their behavior. One way of doing this is contract setting, in which identified behaviors and consequences are agreed upon, written out, and posted in a public area of the house.

Similar to play therapy for children, activity therapy for adolescents utilizes a variety of props and creativity. Creative approaches have been found to be especially effective with adolescents, as they are able to move beyond the realm of simply talk therapy into the realm of transformative experience. Because God is a Creator himself, and he created us with the ability to create also, we serve as a reflection of him when we use our creative abilities in therapy with our clients. Activity therapy makes use of metaphors, symbols, and a wide variety of craft supplies or expressive activities such as pencils, paper, markers, photography, and music. Therapy can be conducted in a directive way, in which the counselor chooses the activities, or a nondirective way, in which the client chooses. New activities or materials do not have to be used every session, and the client should be free to use whatever materials she feels most drawn to as many times as she would like. Stay within the metaphor she creates the entire time if that is most developmentally appropriate for the client’s age, as this can sometimes make processing issues in her life feel less threatening. The counselor should also experience the activities himself before using any of them in therapy with a client; this will help the counselor understand the client’s experiences and also provide personal growth in self-awareness.
Concerning the structure of the actual sessions, Thacker (2018) recommends “to allot five minutes for instruction about the activity, twenty to twenty-five minutes for the activity, and ten to fifteen minutes for processing” (p. 301). It is crucial that the counselor not attempt to interpret the client’s creation, touch it, or provide feedback, even if the client herself does not assign meaning to it. Asking open-ended questions about the creation and about the client’s experience of creating is a wiser approach. Concluding the session in a logical, cognitive way can help the client not feel emotionally exposed when she leaves. Group therapy is another effective option for adolescent clients, as peer relationships are crucial for them during this stage. However, when conducting groups, it is wise to remember to keep confidentiality of each member, especially if parents begin to ask about other children in their child’s therapy group.

**Pedagogical Suggestions:**

- Have students research adolescent brain development in depth as homework using scholarly, peer-reviewed sources and write a brief paper or discussion board post on their findings. Have them focus on addressing how these brain challenges can impact an adolescent and how she experiences the world, as well as how these changes could be utilized to create both positive experiences and negative experiences such as the development of distress and pathology. Conduct a class discussion on their research findings after the homework assignment as well, if desired.
- Discuss as a class or in groups: what, if any, experience do you have interacting with adolescents, either clinically or otherwise, and what has helped you to connect with them? What makes it more difficult to connect?
- Have students independently research activity therapy and different types of activities, consulting a wide variety of sources other than the text, and write a paper or discussion board post on their findings. Instruct them to search for insights and details that are new and not provided in the text. Discuss findings as a class or in groups if desired.
- Have the students gain experience with a variety of activities used in activity therapy. Have them break into pairs or triads and role-play a counseling scenario with an adolescent client, using an activity and structuring the session as recommended in the text. The third person could role-play a parent, if desired.
- Bring in, or have students bring in, various mediums for activities including paper, pencils, markers, clay, coloring books, etc. and have students each create a variety of therapeutic activities they could use in future work with clients. Then, have the students experience for themselves the activities they
created. This could also be done as homework, with a different activity each week (or several at once, if confined to one week), either randomly assigned or chosen by the student. Have students write a brief paper or discussion board post on each experience, how it impacted them, and how they could use it in future counseling (what issues it could be helpful with, etc.).

- Have students choose an expressive therapy—music, poetry, drama, photography, movement, etc.—and create a therapeutic activity, then experience it personally and write about their experience in a paper or discussion board post. This can be done in class or as homework.

Chapter 14 Quiz (25 questions):

Fill-in-the-blank
1. According to Erik Erikson, the major developmental task of adolescence is ______________________. (identity vs. identity confusion)
2. When adolescents are aware of the risks of behaviors yet place more emphasis on the possible positive outcomes of such risky behavior, this is known as ___________________. (hyperrationality)
3. The concept of unconditional positive regard is akin to the theological concept of ___________________. (grace)
4. Parents should provide their adolescent children with age-appropriate opportunities to make decisions in order to encourage independence. This is known as ___________________. (choice giving)
5. __________________ therapy is to adolescents as play therapy is to children. (activity)
6. Because of the social engagement aspect of adolescence, ______________ activity therapy is uniquely suited to meet their developmental needs. (group)
7. Increased novelty seeking for adolescents is due in part to changes within the brain that lead to neural activity utilizing _______________. (dopamine)
8. Some research has indicated that ______________ therapies allow a client to access different aspects of their personal experience that might not be readily accessible with exclusively talk therapy. (expressive)

True/False
1. The need for superficial, shallow bonds with peers is absolutely crucial to healthy adolescent development. (T/F)
2. Adolescent clients do not typically present for counseling on their own volition. (T/F)
3. Clinicians do not need to obtain written parental consent to provide treatment to a minor client. (T/F)
4. Parent consultations throughout the therapy process can be conducted with or without the adolescent present, although it is recommended to include the adolescent to foster trust. (T/F)
5. Due to the nature of activity therapy, metaphors and symbols in creative expression provide a nonthreatening manner for the client to express self. (T/F)
6. Maintaining photographic records of the adolescent client’s created work during activity therapy is not helpful and is frowned upon. (T/F)
7. Concerning the structure of a session for adolescent activity therapy, one should allot a maximum of ten minutes for the activity and twenty to twenty-five minutes for processing. (T/F)
8. When processing the client’s created work in activity therapy, do not touch the client’s creation or give evaluative feedback about the product. (T/F)
9. The counselor should always gain personal experience utilizing each artistic medium prior to incorporating the medium into therapeutic practice. (T/F)

Multiple Choice
1. The acronym ESSENCE, meaning “emotional spark, social engagement, novelty seeking, and creative expression” was coined by ______________ to describe the key features of adolescence.
   a) Siegel
   b) Thacker
   c) Erikson
   d) Yarhouse & Hill
   e) None of the above
2. The main structure in the brain going through major changes during adolescence, according to the text, is:
   a) Prefrontal cortex
   b) Amygdala
   c) Hypothalamus
   d) Temporal lobes
   e) None of the above
3. ________________ is the experience in which clients perceive that you truly understand their experience and “get them.”
   a) Grace
   b) Unconditional positive regard
   c) Feeling felt
   d) Therapeutic alliance
4. All of the following tasks should be accomplished in an initial session with an adolescent’s parents except for:
   a) Obtain a detailed developmental history
   b) Discuss the parents’ expectations for therapy
   c) Allow parents opportunity to speak candidly about the problem
   d) Informed consent
   e) **None of the above**
   f) All of the above

5. A ________________ therapy approach occurs when you allow the adolescent client to lead and select specific activities.
   a) Directive
   b) **Non-directive**
   c) Self-directed
   d) Choice giving
   e) None of the above

6. Examples of expressive activities that can be used in activity therapy include all the following except:
   a) Poetry
   b) Drama
   c) Music
   d) Movement
   e) **None of the above**

7. Which of the following is NOT one of the recommendations to remember when building a therapeutic relationship with an adolescent client?
   a) Reflecting feelings
   b) Reflecting content
   c) Patience
   d) Unconditional positive regard
   e) **None of the above**
   f) Only A and B

8. Which of the following is NOT an aspect of contract setting?
   a) Posting the contract in a public area of the home
   b) Deciding on consequences together
   c) Parents identifying the top 2-3 adolescent behaviors to be addressed
   d) **Adolescents deciding on the top 2-3 parental behaviors to be addressed**
   e) None of the above
Chapter 15
Couple-focused Strategies by Frederick A. DiBlasio, PhD

Key Terms: cognitive behavioral therapy (CBT), integrative behavioral couple therapy (IBCT), emotion-focused therapy (EFT), neuroplasticity, firing, plastic changes, limbic system, amygdala, adrenaline, cortisol, amygdala moment, hippocampus, automatic implicit reactions, oxytocin, neurobiological-integrated couple therapy, personality disorder (PD), emotional and interpersonal dyslexia (EID), forgiveness, checking behavior, improving the fit, accepting and tweaking personality, negotiation, compromise, William James, stroke-kick technique, relationship restoration skills

Key Points:
- Research has shown that cognitive behavioral therapy (CBT), integrative behavioral couple therapy (IBCT), and emotion-focused therapy (EFT) approaches are most effective when counseling couples, promoting calming during moments of conflict and increasing empathy and acceptance.
- Similar to the Christian concept of growing in one’s capacity to love, research has shown that the brain does grow in different ways throughout one’s lifetime, a concept known as neuroplasticity.
- The amygdala is triggered during conflict, activating a person’s survival instincts or “fight/flight/freeze” system. Cortisol and adrenaline are released, causing one’s energy to focus on survival at the expense of high brain functions such as empathy or logical thinking.
- Clients can be taught to recognize when they are emotionally triggered, having an “amygdala moment,” and to calm their amygdala for a few moments before trying to solve a conflict.
- The amygdala also is responsible for releasing oxytocin, considered to be the love/bonding hormone and essential for a marriage relationship; this hormone can be released through touch, kissing, sex, petting an animal, or experiencing empathy, among other ways.
Both negative and positive experiences are believed to be stored in the hippocampus, and the amount of either one can influence the intensity of the amygdala’s reaction to a situation.

Those with a personality disorder (PD) tend to repeat the same relational errors and don’t appear to learn from them, a concept known as emotional and interpersonal dyslexia (EID).

Another useful technique for couples counseling is the clinical use of forgiveness, which must be willingly decided upon by the couple.

“Improving the fit” is a technique in which couples are provided a metaphor of two geometrical angles that (ideally, but don’t always have to) add up to 180 degrees, in which each person is an angle in a particular area.

50/50 compromise is actually not often the best ratio for marriage.

Additional techniques include assessing and tweaking personality, the stroke-kick technique, and relationship restoration skills.

**Student Learning Objectives:**

- To be able to describe the nature of neuroplasticity, the ways in which our brains respond during times of stress and conflict, and how this influences relationships
- To understand how EID, PD, and forgiveness issues impact relationships and the various interventions that can help
- To comprehend the use of oxytocin, compromise, improving the fit, assessing and tweaking personality, the stroke-kick technique, and relationship restoration skills and how these techniques can be applied to couples counseling

**Chapter Summary:**

Research has shown that cognitive behavioral therapy (CBT), integrative behavioral couple therapy (IBCT), and emotion-focused therapy (EFT) approaches are most effective when counseling couples, promoting calming during moments of conflict, and increasing empathy and acceptance. These types of therapy address the physical calming of the brain and creation of new neural pathways, similar to the Christian concepts of renewing the mind and growing in one’s capacity to love throughout the lifespan. Secular approaches tend to emphasize following one’s heart, but Christian counselors recognize that Scripture describes the heart as deceitful and that happiness is not the goal of marriage.

Similar to the Christian concept of growing in one’s capacity to love, research has shown that the brain does grow in different ways throughout one’s lifetime, a concept known as neuroplasticity. DiBlasio (2018) defines
neuroplasticity as “the ability of the human brain to grow stronger through use and stimulation, much like muscles and bodies do when adapting to physical demands like exercise” (p. 313). New pathways, or plastic changes, are formed through repetition and old pathways weaken due to lack of use, although they are usually permanent.

Concerning the structure of the brain, an area of the limbic system considered to be mainly responsible for emotions called the amygdala plays a significant role in relational conflict. The amygdala is triggered during said conflict, activating a person’s survival instincts or “fight/flight/freeze” system. Cortisol and adrenaline are released, causing one’s energy to focus on survival at the expense of high brain functions such as empathy or logical thinking. Over time, this release of cortisol can lead to health problems such as depression, sleep deprivation, and migraines, among many others. It is highly beneficial to begin couples counseling by educating the couple about the brain and the amygdala in particular, and then encouraging them to voluntarily form a contract with each other for treatment. Clients can be taught to recognize when they are emotionally triggered, having an “amygdala moment,” and to calm their amygdala for a few moments before trying to solve a conflict.

The amygdala also is responsible for releasing oxytocin, considered to be the love/bonding hormone and essential for a marriage relationship; this hormone can be released through touch, kissing, sex, petting an animal, or experiencing empathy, among other ways. Oxytocin can “increase contentment, mellowness/calm, security, bonding and attachment, positive social interaction, empathy, loving behaviors, growth, and healing” (DiBlasio, 2018, p. 320). When conducting neurobiological-integrated couple therapy, educating clients on the nature of oxytocin is beneficial, as they can then learn how to increase their own and each other’s oxytocin levels especially during times of stress or conflict.

Educating the couple about the hippocampus is also helpful, as it is highly connected to the amygdala. Both negative and positive experiences are believed to be stored in the hippocampus, and the amount of either one can influence the intensity of the amygdala’s reaction to a situation. This happens when people are “triggered” and react in a way that is out of proportion to the actual situation, because the situation is reminding their amygdala to relive at lighting speed past negative situations in the hippocampus that are similar to the current one. Another name for these instances is automatic implicit reactions. When couples are aware of this, they can learn to recognize how their hippocampus is influencing their current emotions and learn to see their current situations more clearly after calming the amygdala.

In addition to brain education, another important area of education in couples therapy is personality disorders. According to 2008 and 2005 statistics
reported in the chapter, respectively, 9 percent of the general population and 46 percent of the clinical population have a personality disorder (PD). Research has shown that those with a PD have physiological differences in brain structure, function, and connectivity. Additionally, those with a PD tend to repeat the same relational errors and don’t appear to learn from them, a concept known as emotional and interpersonal dyslexia (EID). Several techniques can be used to help address EID, such as providing a diagnosis and explanation in a strengths-based way, seeking support from the spouse, teaching the individual to build new brain pathways and not always trust his emotions, and helping him establish accountability with others.

Another useful technique for couples counseling is the clinical use of forgiveness, which must be willingly decided upon by the couple. It can be done in a five-hour session either at the beginning, middle, or end of counseling, although it can be most beneficial to do it at the beginning. There is a long list of steps involved in this process, but it begins with discussing definitions of forgiveness and explaining the treatment process; each spouse then takes turns walking through the steps of forgiveness with the other. The offender is given the opportunity to explain the offense and to make a plan for not repeating it in the future.

“Improving the fit” is a technique in which couples are provided a metaphor of two geometrical angles that (ideally, but don’t always have to) add up to 180 degrees, in which each person is an angle. Clients can rate each other’s perceived angles as well as their own in any given area, and they often are in agreement about the amount of influence each person has on an issue. Using this visual, couples can decide on which areas each would like to change to create different angles. This can lead into learning about compromise and negotiation techniques, the first of which is letting clients know that 50/50 compromise is actually not often the best ratio for marriage.

When faced with a conflicting issue, first ask each client to rate their position on a scale of 1 to 10 to provide a visual, and then discuss the compromise, which becomes a drastically different conversation when both individuals learn to drop the 50/50 expectation. Related to addressing expectations, couples tend to have idealistic, unrealistic expectations for what a good marriage “should” look like, and helping them realize this can be helpful.

Finally, some additional techniques include assessing and tweaking personality, the stroke-kick technique, and relationship restoration skills. Assessing and tweaking personality is a technique in which clients are taught to celebrate the positive aspects of the other person while also working on the negative aspects in their own personalities. The stroke-kick technique involves preceding a negative statement with a positive one, and usually ending with another positive statement as well so that the negative statement will be better received. Similarly,
relationship restoration skills involve helping the other person feel valued and loved in the midst of conflict or relational stress.

**Pedagogical Suggestions:**

- Have students research CBT, IBCT, and EFT in relation to couples therapy and write a paper or discussion board post on their similarities and differences. Have them research specific techniques associated with each type of therapy and provide a clear explanation of how to use these techniques in therapy with couples.
- Have students discuss (or write a paper or discussion board post) how the concepts of neuroplasticity and neurobiology described in the chapter reflect truths from Scripture, and how this could impact future counseling.
- Have students break into pairs or triads to role-play and practice explaining the neurobiological concepts from the chapter in an easy-to-understand way to a hypothetical client.
- Have students choose a topic from the chapter (such as oxytocin, neuroplasticity, adrenaline, cortisol, etc.) and write a paper or discussion board post, utilizing new information from scholarly sources not presented in the text. Alternatively, students could create PowerPoint presentations for the class. Have them discuss how this new in-depth knowledge could impact their future counseling work, particularly with couples.
- Have students research an aspect of personality disorders or EID and write a discussion board post or paper on their findings, being sure to write about information not provided by the text. Ask them to also write about how this information could influence future counseling.
- Have students break into triads and role-play to practice using DiBlasio’s model of forgiveness with a hypothetical couple. Ask them to also discuss how this model is similar to or different from previous forgiveness models discussed in other chapters, and their opinions on them.
- In role-play triads, have students practice explaining improving the fit, accepting and tweaking personality, and negotiation/compromise techniques to hypothetical clients. They can also practice reducing expectations, the stroke-kick technique, and relationship restoration skills.

**Chapter 15 Quiz (25 questions):**

**Fill-in-the-blank**
1. _________________ is the ability of the human brain to grow stronger through use and stimulation. (neuroplasticity)

2. Repetitive stimulation in the brain, creating an increased protein synthesis of neurons, is known as _____________. (firing)

3. In neurology, the adaptive changes in the brain throughout life are known as ______________________, because the brain can be shaped to almost any form that it is purposed to become. (plastic changes)

4. _________________ is meant to dull the signaling from the amygdala to the higher order cognitive structures so that the person stays in an instinctual survival mode, thus inhibiting logical cognitive thought that can get in the way of fighting or fleeing danger. (cortisol)

5. _________________ is a hormone released in the brain that is known to increase contentment, mellowness/calm, security, bonding and attachment, positive social interaction, empathy, loving behaviors, growth, and healing. (oxytocin)

6. When those with personality disorders continue to repeat the same mistakes over and over without learning from them, this is known as ______________________. (emotional and interpersonal dyslexia, EID).

7. The _________________ is a brain structure not just for negative and hurtful memories, but also for positive and pleasurable ones. (hippocampus)

8. One of the purposes for the _________________ is to provide an automatic, autonomic, conscious, and unconscious mechanism for instinctual self-protection, including emotional and psychological survival. (amygdala)

**True/False**

1. One of the problems with secular couple counseling is that many approaches do not encourage humans to find happiness and follow their hearts. (T/F)

2. In emotional conflict, the amygdala calls for the release of adrenaline and cortisol. (T/F)

3. Research has shown that depriving couples of sleep during conflicts has detrimental effects on the couples’ ability to manage conflict. (T/F)

4. The more negative experiences stored in the hippocampus, the greater the intensity of the perceived danger of the current threat. (T/F)

5. One key function of the amygdala is to activate the secretion of adrenaline, an attachment/love hormone, between husband and wife that bonds them together in a deep neurobiological way. (T/F)

6. 46 percent of the general population are believed to have one or more personality disorders (PD). (T/F)
7. Those with personality disorders have been shown to have brain structures that are smaller, with grey and white matter being less in volume. (T/F)
8. Compromise in marriage should always be 50/50, or close to it. (T/F)
9. Couples often come to therapy with a mind-set of how far short their marriage is from the way a marriage should be. (T/F)

Multiple Choice
1. Which of the following is NOT listed as one of the therapies that is effective with couples?
   a) Cognitive behavioral therapy
   b) Integrative behavioral couple therapy
   c) Emotion-focused therapy
   d) Psychoanalytic couple therapy
   e) None of the above
   f) All of the above

2. At the center of the limbic system are two small brain structures called the ______________, each about the size of an almond, which are thought to create feelings modern society refers to as “the heart.”
   A) Hippocampi
   B) Amygdala
   C) Prefrontal cortex
   D) Temporal lobes
   E) None of the above

3. When humans are emotionally hurt or under emotional threat, the ______________ is activated much like it is when under physical threat.
   a) Amygdala
   b) Hippocampus
   c) Temporal lobe
   d) Prefrontal cortex
   e) None of the above

4. Which of the following problems is NOT associated with chronic release of cortisol?
   a) Depression
   b) Sleep deprivation
   c) Migraines
   d) Chronic fatigue
   e) None of the above
   f) All of the above
5. When couples are given the geometrical metaphor of supplementary angles and are asked to rate themselves and each other across a wide array of subjects, this technique is known as:
   a) The supplementary angle technique
   b) **Improving the fit**
   c) Accepting and tweaking personality
   d) Improving the angle
   e) None of the above

6. ________________ is credited with creating the concept of happiness as a ratio of perceived reality divided by expectations, a useful formula in couples therapy.
   a) William James
   b) DiBlasio
   c) Hippocrates
   d) Zimmerman
   e) None of the above

7. ________________ involve(s) the direct intent to do or say something during tense moments to show the other that he or she is valued and loved.
   a) The oxytocin technique
   b) **Relationship restoration skills**
   c) The stroke-kick technique
   d) Assessing and tweaking personality
   e) None of the above

8. Which of the following is NOT one of DiBlasio’s first three steps of forgiveness?
   a) The focus on each person having the opportunity to seek forgiveness for his or her wrongful actions is established.
   b) Definitions of forgiveness are discussed.
   c) The treatment process is introduced, and the couple decides whether to participate.
   d) **The couple completes a ceremonial act to celebrate the forgiveness decisions made.**
   e) None of the above
Key Terms: functional family therapy (FFT), systemic family therapy (SFT), brief strategic family therapy (BSFT), multisystemic therapy (MST), hierarchy, reciprocity, Murray Bowen, John Weakland, Gregory Bateson, Jay Haley, Milton Erikson, Virginia Satir, Salvador Minuchin, structural family therapy, Harry Aponte, Cloe Madanes, strategic family therapy, enactments, directives, boundaries, enmeshed boundaries, nurturance, process, outcome, peripheral parent, parent coaching, time-out

Key Points:

- DiBlasio (2018) defines systemic family therapy as focusing on “how the system created by the family through healthy and unhealthy dynamics impacts the emotional and relational health of the family members” (p. 334).
- Historically, official counseling work with families did not begin until the 1950s when several famous individuals attempted to seek a cure for schizophrenia by postulating that whole families needed to undergo therapy; in these times, schizophrenia was thought to originate from dysfunctional family patterns.
- Scripture provides a template for family therapy by describing the ideal hierarchy and structure of the Christian family, with the parents at the top of the hierarchy and children below them.
- The counselor can use a wide variety of techniques from a systems-oriented perspective when dealing with family situations in therapy; these techniques include enactments, inducing enactments, using directives, interrupting dysfunctional patterns, setting healthy boundaries, using nurturance to elevate hierarchy, empowering parents to win the process and outcome,
staying focused on the present problem, increasing involvement of the peripheral parent, and parent coaching.

**Student Learning Objectives:**

- To comprehend the nature and history of family therapy, including the different pioneers and their contributions
- To understand the Bible’s views on family, including dynamics and structure
- To be able to describe the various techniques that can be used in therapy to address family dynamics, patterns, and struggles

**Chapter Summary:**

Many different types of therapy have been shown to be effective with families, including functional family therapy (FFT), brief strategic family therapy, multidimensional family therapy (MDFT), multisystemic therapy (MST), and systemic family therapy (SFT), but all of them have in common a systems-oriented approach. This is based on the idea of reciprocity, or the idea that one family member’s behavior affects and is influenced by the behavior of all other family members. DiBlasio (2018) defines systemic family therapy as focusing on “how the system created by the family through healthy and unhealthy dynamics impacts the emotional and relational health of the family members” (p. 334).

Historically, official counseling work with families did not begin until the 1950s when several famous individuals attempted to seek a cure for schizophrenia by postulating that whole families needed to undergo therapy; in these times, schizophrenia was thought to originate from dysfunctional family patterns. Therapists involved in this work included Murray Bowen, John Weakland, Gregory Bateson, Jay Haley, Virginia Satir, Salvador Minuchin, Harry Aponte, and Cloe Madanes. Jay Haley in particular, influenced by Milton Erikson, is known for directing the Mental Research Institute (MRI) and being the first editor of the journal *Family Process*. Minuchin and others developed structural family therapy, while Madanes and Haley developed strategic family therapy. Both types of therapy involved a team of counselors watching a family session through a one-way mirror and sharing ideas live with the counselor in the other room.

Scripture provides a template for family therapy by describing the ideal hierarchy and structure of the Christian family, with the parents at the top of the hierarchy and children below them. This is supported by several verses that illustrate how parents are to love and discipline their children, as well as the famous Ephesians 5:22-6:4, which discusses the relationship between husband and wife and the concepts of unity and self-sacrifice among family members. Additionally, the body of Christ metaphor can be used to help illustrate a healthy
family dynamic where each member is valued and both unity and uniqueness are present. With these scriptural illustrations in mind, the counselor can use a wide variety of techniques from a systems-oriented perspective when dealing with family situations in therapy; these techniques include enactments, inducing enactments, using directives, interrupting dysfunctional patterns, setting healthy boundaries, using nurturance to elevate hierarchy, empowering parents to win the process and outcome, staying focused on the present problem, increasing involvement of the peripheral parent, and parent coaching.

Enactments are family dynamics or patterns naturally occurring in the present moment, easily observable by the counselor. Sometimes the counselor can choose to induce an enactment, which simply consists of asking the family to discuss an issue or engage in an activity that the counselor suspects will illustrate the family’s dynamics and patterns in the therapy session. After the counselor is able to observe such patterns, there are several options for intervention. Directives can be used, which are tasks or assignments for the family to complete either in session or at home that help them to establish healthier dynamics and patterns. The counselor can also interrupt dysfunctional patterns, which usually involves explaining the observed dysfunctional pattern to the family and then subtly finding ways to interrupt it when it happens in session. It is also important to pay attention to boundaries, as sometimes they can be too close (enmeshed) or too rigid. A child and parent reversing roles is typically the most common type of boundary issue, and it is necessary to address this so that the parent can be established at the top of the hierarchy.

One way of helping the family establish a healthy hierarchy system is by using nurturance. When parents provide nurturance to children, they are naturally creating a hierarchy where the parents are at the top. This can be helpful in role-reversal situations because the child is not the one nurturing the parent. Nurturance also releases oxytocin and helps the parent bond with the child. Empowering parents to win the process and outcome is another technique that can be beneficial when children are challenging the hierarchy of the parent; process refers to all the behaviors and exchanges in a given interaction and outcome refers to the end result of the given interaction. Often parents will use yelling, threats, or force to win the outcome, but this results in losing the process. Educating parents on the difference between process and outcome can help them learn to win both rather than just the outcome, improving their relationship with their child and establishing the proper family hierarchy.

However, education alone is not enough, and sometimes direct education is not helpful, so it is important for the counselor to remember this. Relatedly, another technique that can help is staying focused on the presenting problem; by doing this, rather than pointing out dysfunctional family patterns or educating the
family, counseling can create tangible results and also create a better relationship between the parents and counselor. In cases where there is a peripheral or underinvolved parent, there is also usually an overinvolved parent, and usually the overinvolved parent is the mother. When this occurs, it is beneficial to help the parents learn to balance each other out, and this often solves many family issues as well as the dynamics change.

Finally, parent coaching is often a useful approach for most mild or moderate child-related problems. For this approach, it is recommended to meet first with only the parents, and then continue to meet with only the parents unless it becomes necessary to include the other family members. Teaching the time-out technique is one aspect of parent coaching that is especially important. Before beginning this teaching process, it is essential to explain to the parents the philosophy behind the technique and how its goal is to help foster a godly family environment of love. Then, the parents are to also explain this rationale to their children in an initial family meeting to explain the new technique to the children. The parents can also use this time to apologize and seek forgiveness for past discipline experiences in which they were overly angry, if necessary. Then the parents explain the procedure for the technique, practice it, utilize it when an offense occurs, and then discuss afterwards the child’s thoughts about the offense and have the child ask for forgiveness.

**Pedagogical Suggestions:**

- Have students research functional family therapy (FFT), systemic family therapy (SFT), brief strategic family therapy (BSFT), multidimensional family therapy (MDFT), and multisystemic therapy (MST) and write a paper or discussion board post on the similarities and differences. Have a class discussion on the students’ opinions on these therapies after their research.
- Have students write a paper on (or have a class discussion on) their own philosophies of parenting and family, and how these views could affect their future counseling. Ask them to discuss the biblical support for family structure and dynamics presented in the text, and how they would handle a client who has a different view of family either different from theirs or different from that described in the Bible.
- Divide students into groups and have them choose one of the case studies from the text to role-play to practice the associated family therapy techniques.
- Divide students into groups and have them role-play any of the family therapy techniques from the text.
• Have students break into groups and practice teaching the time-out approach to hypothetical clients. Then, have the “clients” practice implementing the approach with the “child.” Switch out roles and/or change group members so that students get a chance to practice different roles.
• As a class, watch a brief episode of a family-friendly, family-focused television show, and then discuss the family dynamics and patterns they noticed in the TV family members. Discuss techniques from the text that could be helpful in different situations from the show. This can also be assigned as homework, and each student can write a paper or discussion board post.
• Have students break into groups and create PowerPoint presentations on one of the pioneers of family therapy, discussing how this person contributed to the field and how the information learned from this assignment could be helpful in future counseling. Make it a competition to see who can make the most creative, impactful presentation.

Chapter 16 Quiz (25 questions):

Fill-in-the-blank

1. _______________ is the concept that human behavior does not occur in a vacuum but instead is highly influenced as a response and interconnectedness to others. (reciprocity)
2. _______________ focuses on how the system created by the family through healthy and unhealthy dynamics impacts the emotional and relational health of the family members. (systemic family therapy)
3. _______________ are tasks that the counselor asks a family to do in session or to accomplish at home for the purpose of building a healthier pattern of behavior between family members. (directives)
4. Boundaries that are too close are known as _______________. (enmeshed)
5. The _______________ of an interaction is all of the behavioral sequences that occur within the parent-child interaction. (process)
6. _______________ usually works for mild to moderate child-related problems, meeting only with the parents rather than the whole family. (parent coaching)
7. When the counselor asks the family to do or discuss something that is likely to evoke the family dynamics in the session, this is called _______________. (inducing an enactment)
8. Salvador Minuchin, along with others, is known for developing _______________ therapy, having come to the United States with the
systemic ideas of family dysfunctional structure and patterns. (structural family)

True/False
1. One of the classic principles of family therapy is realigning family hierarchy so that parents are in charge of their children. (T/F)
2. In a family session, pointing out the dysfunctional pattern before interrupting it is not necessary. (T/F)
3. The most common boundary intrusion occurs when a child becomes a parental child and/or a parent becomes more childlike. (T/F)
4. A by-product of the parent giving nurturance is an elevation of hierarchy. (T/F)
5. It is unusual for children to systematically step into the role of absent parent while also filling the single parent’s need for companionship. (T/F)
6. Parents coming in for family treatment usually do not fear that counselors will blame them for the child’s problem. (T/F)
7. When there is an acting-out child or child with a presenting problem, often one parent is more involved than the other. (T/F)
8. Fathers tend to be overly involved in child problems, and mothers tend to take on more peripheral roles. (T/F)
9. Minuchin and Haley were against the idea of having a team of people in one room calling in instructions during a live family session in the adjacent room. (T/F)

Multiple Choice
1. Which of the following is NOT one of the therapies listed as being effective with families?
   a) Multidimensional family therapy (MDFT)
   b) Functional family therapy (FFT)
   c) Systemic family therapy (SFT)
   d) Brief strategic family therapy (BSFT)
   e) None of the above
   f) All of the above

2. ____________________ was a pioneer and leader in the family field, a director of the Mental Research Institute (MRI), and the first editor in the 1950s of the prestigious Family Process journal.
   a) Murray Bowen
   b) Jay Haley
   c) Milton Erikson
   d) John Weakland
3. Strategic family therapy was created by:
   a) Haley and Madanes
   b) Madanes and Satir
   c) Haley and Weakland
   d) Haley and Satir
   e) None of the above

4. ________________ refer to manifestations of patterns and behavioral sequences that are occurring live so that they can be observed by the counselor, and thereby predisposed for direct intervention to address them.
   a) Directives
   b) Enactments
   c) Live observations
   d) Live behavioral windows
   e) None of the above

5. When the parent controls negative emotions and behaviors, and maintains loving authority during a conflict, this is known as:
   a) Winning the process
   b) Winning the outcome
   c) Using a directive
   d) Staying focused on the present problem
   e) None of the above

6. ________________ and Madanes emphasized that therapy should start by keeping the focus on the presenting problem and choosing a treatment strategy to resolve it in as brief a time as possible.
   a) Minuchin
   b) Haley
   c) Satir
   d) Bowen
   e) None of the above

7. Which of the following is NOT one of the steps involved in the time-out procedure?
   a) Set a private pretend practice time for each child
   b) When a child commits a violation, calmly request that the child go to the time-out chair or mat
   c) After the time-out, discuss the violation and why the child thinks the violation was wrong
   d) If the child refuses to go to the chair or mat, sit on the chair or mat with the child and talk to him throughout the time-out
   e) None of the above
8. The concept of professional work with families began in:
   a) The 1940s
   b) **The 1950s**
   c) The 1960s
   d) The early 1900s
   e) None of the above
Chapter 17

*Family-of-origin-focused Strategies* by Frederick A. DiBlasio, PhD

**Key Terms:** family of origin therapy, counselor self-development, James Framo, Harry Aponte, the person-of-the-therapist model, Freytag, introduction, rising action, climax, falling action, denouement, inertia effect, enthusiasm, perceptions, self-accountability segment, forgiveness, personality disorder (PD), emotional and interpersonal dyslexia (EID)

**Key Points:**
- Family of origin therapy involves a counseling session, or several, with one’s family of origin, usually to address past issues from one’s childhood, work through forgiveness, and hopefully restoration of relationships.
- Adults, including counselors themselves, can still be heavily influenced by their family of origin, either in their current relationships with others or their own internal struggles.
- A pioneer in the field of family of origin therapy, James Framo recommended family of origin counseling to take place in a one-time session, spread out over two days for about four hours each day with both a male and female counselor present.
- Harry Aponte’s model focuses on the person of the counselor, how the counselor can be affected by family of origin in his professional work, and how working through such issues can result in better care for clients.
- Counseling sessions can be compared to the five stages of a dramatic production proposed by Freytag, and the inertia effect can explain why long counseling sessions can be beneficial.
- It is important for the counselor to be enthusiastic and to personally invite potentially unwilling family members to a family of origin session.
- Steps to a productive family of origin session include educating the family on respecting each other’s perceptions, sharing positive family memories, self-accountability, resolution, and seeking the spiritual value from past difficulties.

**Student Learning Objectives:**
- To understand the purpose and benefits of family of origin therapy
• To be able to describe the two models of family of origin therapy presented by Framo and Aponte
• To comprehend the structure, challenges, and various steps involved with conducting family of origin sessions

Chapter Summary:

Family of origin therapy involves a counseling session, or several, with one’s family of origin, usually to address past issues from one’s childhood, work through forgiveness, and hopefully restoration of relationships. Benefits include potential reconciliation in one’s familial relationships, improvement in one’s marital and other relationships, and improvement in one’s own internal struggles such as self-esteem. Scripture is replete with illustrations of a healthy family, as well as the value of family, such as Jesus’s care for his mother and the story of the prodigal son. Also illustrated in Scripture are examples of family tragedy, such as situations where an adult child rejects God or other evil behavior occurs, such as in the family of Joseph.

Concerning the psychology of family of origin issues, adults can still experience emotional abuse from their families through their family members’ current treatment of them, through unconsciously being drawn to similar dysfunctional relationships, or through internalizing the abusive voices. Issues with one’s spouse can often be influenced by past family of origin issues. One’s work as a counselor can also be affected by past family of origin issues, as certain populations or issues can be triggering of childhood struggles.

Two pioneers in the field of family of origin therapy, James Framo and Henry Aponte, are worth studying for their useful contributions of SITs. Framo recommended family of origin counseling to take place in a one-time session, spread out over two days for about four hours each day. He prescribed that both a male and female counselor conduct the session, so that both gender dynamics can be experienced and the chances of a counselor being caught up in the family’s issues is reduced. The counselors begin by building rapport, then move into the working phase of the session. To conclude, the counselor summarizes the themes of the session and helps the family end on a positive note. Aponte, however, focused his model on the person of the therapist and how difficulties in their profession can stem from their own family of origin. Gaining awareness of the family of origin’s influence is the first step, and then supervision or personal counseling can be sought to help address past unresolved issues.

DiBlasio suggests that there are several benefits to Framo’s idea of long sessions with families, citing the work of Freytag who described the counseling session as similar to a dramatic production with five stages: introduction, rising
action, climax, falling action, and the denouement, which is the conclusion. The inertia effect is another reason that long sessions can be helpful, as the “climax” is considered the most productive stage of a session and more momentum can be theoretically achieved with more time.

When considering family of origin sessions, there can be several concerns that must be navigated. Most considerations begin during individual or couples therapy when the counselor notices that past family issues on one or both sides may be affecting current relationships or life situations. DiBlasio notes that it is important for the counselor to display enthusiasm about family of origin sessions, as this can help clients be more willing to participate. It is also important to mention that the sessions will be only for the family of origin and spouses or in-laws are not to be included, as they were not part of the original family unit. Clients often report that various family members would likely not be willing to come to such a session, and DiBlasio recommends that the counselor can ask permission to personally call and invite the other family members himself. People tend to be more willing to say yes when the counselor invites them personally and uses a positive, strength-based communication style in the invitation.

When conducting family of origin sessions, the first step is often to help the family members learn to respect each other’s perceptions. The counselor can educate them on reasons why no two people will ever have the exact same perception of a situation, such as personality differences, gender differences, differences in developmental stages, neurobiological differences in memory storage, and individual differences. Then, the counselor can ask each person to share a positive family memory to help begin dialogue and ease anxiety. This can be followed by a period of self-accountability where each person chooses a negative behavior he can take responsibility for and seek forgiveness from other family members. The counselor should remember that this part may be difficult for any family members who have a personality disorder. Additionally, it is important to help the family stay focused on resolution and making a plan to not repeat each offense in the future. Towards the end of the session, the counselor can help the family to find the spiritual value in their past, to notice how God can or did use past pain for good.

**Pedagogical Suggestions:**

- Have students do additional research on Framo and Aponte and their perspectives on family of origin therapy; they can present their findings with a PowerPoint presentation, discussion board post, or class discussion.
- Ask students to choose a family scenario in the Bible and to write a brief discussion board post or paper on how the family illustrates either the
importance/value of family or one of the other family issues described in the chapter under the theology section.

- Framo is quoted in the text as saying, “Then there are some things that women go through that only men can understand, and some things men go through that only women can understand.” Ask students to break into groups or have a class discussion (or write a discussion board post) on this quote, what they think it could mean, how it could impact counseling, and what some examples could be.

- Have students break into groups and role-play to practice a short-version of Framo’s family of origin session, going through the three stages described in the text. They can take turns playing the counselor.

- Ask students to list any populations or issues that they feel are or could be difficult for them in their future counseling work, and to examine or discuss in pairs if or how they feel their family of origin influences these struggles. Talk with each pair and help them through any questions they might have. Then ask them to do the opposite and examine if or how their family of origin could have influenced their strengths as a counselor and issues/populations they feel drawn to or work well with.

- Have students break into triads and role-play a counselor working with a client who claims their family members would probably be unwilling to come to a family of origin session. Have the “counselor” move through the steps listed on page 363 of the text for personally inviting reluctant family members to a session. The third student can role-play each family member.

- Have students break into groups and role-play a DiBlasio style family of origin session as described in the text, moving through all the steps such as explaining to the family the importance of respecting each other’s perceptions, discussing pleasant memories, etc.

- Have students role-play in groups the same previously described family scenario, with one of the family members having a personality disorder.

Chapter 17 Quiz (25 questions):

Fill-in-the-blank
1. _______________ was a pioneer in advocating that intense short-term therapy with family of origin members can produce lasting positive results. (Framo)
2. _______________ was instrumental in providing a theoretical framework for helping practitioners to think about intergenerational patterns. (Bowen)
3. Aponte’s model, the ________________ model, involves a focus on family of origin influence on counselors’ practices. (person-of-the-therapist)

4. DiBlasio cites ________________’s work to describe counseling sessions as similar to dramatic productions. (Freytag)

5. The second stage of a dramatic production or counseling session is called ________________. (rising action)

6. DiBlasio states that a family of origin session should begin with sharing ________________. (positive family memories)

7. The section of a family of origin session where each family member takes personal responsibility for an offense or negative behavior is called the ________________. (self-accountability segment)

8. When family members are struggling with the pain from the past, DiBlasio urges them to ________________ the past and focus on how God can or has used their pain for good. (spiritually embrace)

True/False

1. Current attachment issues with one’s spouse can be related to past issues with one’s family of origin, according to research. (T/F)

2. One of the reasons that Framo recommended both a male and female counselor be present for family of origin sessions is that when alone a counselor can be easily and unknowingly drawn into family dysfunction. (T/F)

3. One of the reasons that Framo recommended both a male and female counselor be present for family of origin sessions is that “there are some things that women go through that only men can understand, and some things men go through that only women can understand.” (T/F)

4. The second portion of a Framo family of origin session involves building rapport with the family members and reducing their anxiety. (T/F)

5. There are four stages of a dramatic production or counseling session. (T/F)

6. If counselors are enthusiastically convinced about the treatment they provide, clients are more willing to attempt and to benefit from treatment. (T/F)

7. The family of origin session is open to spouses and other family friends, if desired. (T/F)

8. It is unusual for clients to have a negative viewpoint regarding whether a family member would agree to come in for a family of origin session. (T/F)

9. Those with personality disorders do especially well with self-accountability. (T/F)
Multiple Choice
1. All of the following are benefits of family of origin therapy EXCEPT:
   a) Improving current family interactions
   b) Improving interactions with others
   c) Addressing internal difficulties
   d) **Providing a space for venting and catharsis**
   e) None of the above
2. Adults can continue to experience emotional abuse from their family of origin through all of the following EXCEPT:
   a) Internalizing the abusive treatment
   b) A propensity to find others who continue the abusive pattern
   c) Present dysfunctional treatment from family members
   d) **Poor self-efficacy and low self-worth**
   e) None of the above
3. Framo originally recommended that a one-time family of origin session be split up between two days, with a total of approximately ______________ hours.
   a) 4
   b) 6
   c) 8
   d) 10
   e) None of the above
4. The term for a counseling session’s success due to momentum is:
   a) The rising action
   b) The falling action
   c) **The inertia effect**
   d) The momentum effect
   e) None of the above
5. Which of the following is NOT one of the three ways in which family of origin sessions usually come about, according to the text?
   a) During an individual therapy session, unresolved issues come to light
   b) Families call directly once the therapist has a reputation
   c) Issues come up during couples therapy
   d) **Issues come up during inpatient hospitalization**
   e) None of the above
6. All of the following are reasons that family members can have different perceptions EXCEPT:
   a) Gender differences
   b) Personality differences
   c) Implicit reactions in the brain’s hippocampus
d) Difference in developmental stages
    e) None of the above
    f) All of the above

7. DiBlasio states that there are 7 reasons for why he believes family of origin therapy is effective, particularly towards the end of a session. Which of the following is NOT one of those reasons?
   a) The inertia effect
   b) Much prayer has been involved
   c) More client motivation due to self-accountability and a non-defensive environment
   d) God is pleased to have his children “speak the truth in love.”
   e) None of the above
   f) All of the above

8. One particular group of disorders one should always assess for when doing family of origin therapy is:
   a) Personality disorders
   b) Anxiety disorders
   c) Depressive disorders
   d) Cognitive disorders
   e) None of the above
Key Terms: conflict, family development, system theory, content, process, social learning theory, modeling theory, emotional security theory (EST), cognitive contextual theory, Bowlby, attachment, Gottman conflict styles, avoidant style, volatile style, validating style, hostile style, Thoman-Kilman conflict styles, avoider style, competitive style, collaborative style, compromising style, accommodating style, conversational orientation, conformity orientation, authoritarian parenting style, authoritative parenting style, permissive parenting style, dialectical behavior therapy (DBT), emotion-focused family therapy (EFFT), emotion-focused therapy (EFT), the Maudsley approach, structural and Bowenian family therapy, triangulation, the Gottman method, the four horsemen, Gottman’s sound relationship house theory, peacemaker

Key Points:

- Conflict, believed to be driven by a search for resources and/or power, is a normal part of family life, and can be especially prominent during various stages of a family’s development such as marriage, having young children, or having teenagers.
- There are several theories to explain how conflict is learned, influenced by various factors, and how it impacts children, including social learning theory, modeling theory, emotional security theory, cognitive contextual theory, attachment theory, and cultural factors.
- The Gottman conflict styles can be divided into four categories: avoidant, volatile, validating, and hostile. A mismatching of styles is the most likely to create frequent conflict.
- The Thomas-Kilman conflict styles are divided into five categories: avoider, competitive, collaborative, compromiser, and accommodator. A questionnaire developed by Thomas and Kilman examines the factors of assertiveness and cooperation to classify individuals into one of the five categories.
- Families can be rated high or low on two orientation types: conversational and conformity.
• Parenting styles can be divided into three types according to Baumrind: authoritarian, authoritative, and permissive.

• Effective treatment methods for family conflict discussed in this chapter include Dialectical Behavior Therapy (DBT), the Maudsley approach, structural and Bowenian family therapy, emotion-focused family therapy (EMFT), emotion-focused therapy (EFT), and the Gottman Method, as well as teaching a few extra skills such as self-efficacy, mastery, and utilizing one’s voice.

• Giving structured conflict practice assignments to families/couples and discussing the biblical position of peacemaker can be beneficial.

Student Learning Objectives:

• To be able to describe the impact of, theories related to, and factors that contribute to family conflict and one’s experience of it

• To understand the different methods of assessment for family conflict issues

• To comprehend the myriad treatment methods recommended for working with family conflict

Chapter Summary:

Conflict, believed to be driven by a search for resources and/or power, is a normal part of family life, and can be especially prominent during various stages of a family’s development such as marriage, having young children, or having teenagers. Conflict behavior that is maladaptive, especially concerning anger and avoidance, has been shown to correlate with multiple long-term health problems, but research has actually shown that experience with healthy conflict and resolution can be beneficial. Systems theory, often used in family therapy approaches to conflict, recommends that families be assessed as a whole, and the parts that make up the whole should be assessed as well. Additionally, both the process and content of the family members’ interactions during conflict should be attuned to and assessed by the counselor. Based on these general guidelines, this chapter examines influencing factors, assessment protocols, treatment methods, and relevant biblical values to address conflict in family therapy sessions.

There are several theories to explain how conflict is learned, influenced by various factors, and how it impacts children. According to social learning theory and modeling theory, children learn patterns of behavior for handling conflict from their parents. The emotional security theory (EST) and the cognitive contextual theory both provide explanations for how conflict between parents affects the family. Children are thought to draw their sense of emotional security from the meaning they derive from parental conflict, according to EST. Similarly, cognitive
contextual theory illumines the ways in which children ascribe meaning to conflict based on past experiences and personal interpretations. It is also necessary to remember that cultural factors can influence these ascriptions of meaning, as cultures interpret conflict in a wide variety of different ways. The ability to cope and thus handle conflict well is influenced additionally by attachment style, divided by Bowlby into secure, avoidant, ambivalent, and fearful/disorganized.

Beneficial assessment models are available, including the Gottman conflict styles and the Thomas-Kilman conflict styles. The Gottman conflict styles can be divided into four categories: avoidant, volatile, validating, and hostile. A mismatching of styles is the most likely to create frequent conflict, although two people with the same style can have conflict as well. The avoidant style involves focusing on the positive aspects of the relationship at the expense of the negative, choosing not to address conflictual issues and let the passage of time solve any problems. Those with a volatile style are the opposite, aware of their opinions and expressive, often with intense or dramatic verbiage; they emphasize honesty, but they are not emotionally cruel. The validating style is seen as the most effective, healthiest style, focusing on compromise, listening, and empathy while also being assertive. As can be inferred from the name, the hostile style is the most unhealthy, involving criticism, blaming, and emotional attacks on the other person.

The Thomas-Kilman conflict styles are similar, but also different, and are divided into five categories: avoider, competitive, collaborative, compromiser, and accommodator. A questionnaire developed by Thomas and Kilman examines the factors of assertiveness and cooperation to classify individuals into one of the five categories. The avoider category is the same dynamic as described in the Gottman model. The competitive category prioritizes being right and getting what one wants no matter what. The collaborative style is similar to Gottman’s validating style, utilizing assertiveness and cooperation. The compromiser style is self-explanatory, and the accommodating style involves putting aside one’s needs in favor of the other person’s.

It is also valuable to assess a family’s orientation and parenting styles, as well as be aware of the stages of conflict—prior conditions, frustration, active conflict, solution or non-solution, follow-up, and resolution—in order to guide the family through them in a healthy way. Families can be rated high or low on two orientation types: conversational and conformity. Conversational is the degree to which family members can freely share their thoughts and opinions, and conformity is the degree to which family members are implicitly required to agree. Parenting styles can be divided into three types according to Baumrind: authoritarian, authoritative, and permissive. Authoritative is considered to be the most effective style, involving both nurturance and parental control. The authoritarian style uses little nurturance and a high degree of control, and the
permissive utilizes strong nurturance but weak control. Families often find the results of these assessments to be insightful and incredibly beneficial. After the assessment process, a treatment method can be selected based on the family’s needs and goals. Effective treatment methods for family conflict discussed in this chapter include Dialectical Behavior Therapy (DBT), the Maudsley approach, structural and Bowenian family therapy, emotion-focused family therapy (EMFT), and the Gottman Method, as well as teaching a few extra skills such as self-efficacy, mastery, and utilizing one’s voice. Furthermore, giving structured conflict practice assignments to families/couples and discussing the biblical position of peacemaker can be beneficial.

Dialectical Behavior Therapy (DBT) involves learning a wide variety of skills that assist in emotion regulation and interpersonal interactions, such as mindfulness, interpersonal effectiveness skills, and tolerating distress. Each skill involves a series of “how to” steps and are learned through repeated practice. The Maudsley approach was created to help the families of young adults living at home or adolescents with eating disorders. Parents actively help their child recover while displaying a unified front, and problematic family conflict styles are shifted to more healthy ones. Structural and Bowenian approaches are based on the idea that families are composed of triangles, and work to de-triangulate children who have ended up in an unhealthy position. Emotion-focused family therapy (EMFT) asserts that dysfunctional family behavior is based on attachment and emotion regulation issues, and seeks to create healthier relationships among family members by changing interactional patterns during conflict.

When focusing on couples and the marital relationship, there are two methods that have been shown to be especially helpful. The Gottman Method teaches couples to control their arousal through self-soothing and reduce criticism, defensiveness, contempt, and stonewalling, also known as the “four horsemen.” Controlling arousal during conflict is essential, as Gottman found that when one’s heartrate rises above 100, one becomes flooded with emotion and finds it more difficult to listen to others. Couples also learn to increase positive affect during conflict and focus on having positive relational experiences when conflict is not occurring, an aspect of Gottman’s sound relationship house theory. Six steps can also be taught to the couple to help them process conflict: “sharing feelings, describing each partner’s subjective reality, sharing attachment issues, checking emotional arousal (flooding), acknowledging responsibility, and problem solving a way to make the fight better” (Mintle, 2018, p. 394).

Another effective approach with couples is emotion-focused therapy (EFT), similar to the emotion-focused family therapy (EFFT) described in brief previously. This approach focuses on helping the clients view each other as a safe haven where they can emotionally engage and empathize together. They are taught
to make repairs after conflict via apologies and forgiveness, and to focus on strengthening their bond of friendship.

Finally, Mintle provides a ten-step process that can be taught to families to help them practice conflict well at home; this process includes evaluation questions at the end to help family members determine if the steps were helpful or not. Additionally, she discusses the biblical concept of peacemaker, stating that people often mistakenly believe that being a peacemaker means avoiding conflict. It is important to explain this false idea and the correct definition of a peacemaker to Christian families or couples as they struggle with conflict. In a seven-step process, Mintle suggests that peacemakers make a decision to address the conflict, begin with prayer, listen to the other person’s viewpoint, take responsibility, speak the truth in love, forgive, and work towards solutions.

**Pedagogical Suggestions:**
- Using both the Gottman conflict styles and the Thomas-Kilmann styles, have students identify their own preferred conflict style from each, as well as the conflict styles of their family members while they were growing up. Ask them to note any mismatches, matches, or ways in which the style of a parent was passed down to a child. Have a class discussion, or break into groups to discuss their findings and reactions. Ask students to explain how they and their family members exemplified certain styles. Ask them how, if at all, they think their personal conflict style could affect their counseling work.
- Choosing either the Gottman styles or the Thomas-Kilmann styles (or both), write the names of each style on a slip of paper and put them in a bowl or other container. Have each student draw a piece of paper, keeping it to themselves. Then have the students come up two at a time and role-play a conflict or argument, illustrating their conflict styles. The class could offer up ideas or vote on what the conflict should be about. After the brief role-play, have the class guess which conflict styles were being demonstrated.
- Have students break into groups and role-play a family counseling scenario, choosing either dialectical behavioral therapy, the Maudsley approach, emotion-focused family therapy, or structural and Bowenian family therapy. Students may research these approaches in more detail the week before the role-play exercise as homework, if desired, or during class before the role-play if resources are available.
- Have students conduct further research on both the Gottman Method and Sue Johnson’s emotion-focused therapy (EFT), then construct a paper, discussion board post, or PowerPoint presentation on the similarities and
differences between the two, as well as a detailed description of each and how one could go about becoming trained in them as a counselor.

- After studying Mintle’s ten-step process for structured practice with conflict, have students break into “family” groups and role-play working through a conflict while following these steps. Before practicing, have one student volunteer to teach the other group members the steps as if he or she were their family counselor.

- Have students break into pairs and practice teaching each other the seven steps of Mintle’s peace process, with one student role-playing the client and the other role-playing the counselor. Then, have them switch roles. The goal is for the students to be able to teach the process without looking at the text or any other resource. Ask students to discuss their thoughts about these steps after the role-play.

Chapter 18 Quiz (25 questions):

Fill-in-the-blank

1. Family conflict is influenced by resources and __________________. (power)
2. __________________ theory posits that it is the meaning of interpersonal and family conflict that relates to a child’s assessment of emotional security. (emotional security)
3. __________________ theory states that the way people make sense of conflict is influenced by experiences, recollections, and interpretations. (cognitive contextual)
4. The Thomas-Kilmann assessment instrument measures individuals on two factors, assertiveness and ____________________. (cooperativeness)
5. __________________ is a family based treatment developed for adolescents with eating disorders and young adults living at home. (the Maudsley approach)
6. __________________ theory stresses the importance of knowing your partner through friendship, expressing fondness and admiration, turning toward the partner, and building a positive relationship when conflict is not present. (Gottman’s sound relationship house)
7. Families often confuse making peace with __________________. (avoidance)
8. __________________ is the fourth step in the seven steps to help families address the peace process when family conflict occurs. (take responsibility)
True/False

1. Research has shown that there are no long-term health consequences associated with family conflict. (T/F)
2. Conflict activates attachment style. (T/F)
3. Those with a volatile conflict style are clear about their opinions and have no problem arguing and persuading. (T/F)
4. A validating conflict style is superior to other styles in terms of couple satisfaction and stability. (T/F)
5. Baumrind (1973) categorized parenting styles into three basic types: authoritarian, authoritative, and permissive. (T/F)
6. The last stage of family conflict, according to Galvin, Braitwaite, and Bylund (2016), is the follow-up stage. (T/F)
7. Structural and Bowenian family therapy include the technique of detriangulation. (T/F)
8. When a person’s heart rate rises above 100, he is flooded with emotion, inhibiting listening. (T/F)
9. According to Gottman’s research, healthy couples have a five-to-one ratio of positives to negatives in their relationship. (T/F)

Multiple Choice

1. Both social learning theory and ________________ posit that children learn behavior patterns in their families, and parents are the models for conflict behavior.
   a) Modeling theory
   b) System theory
   c) Cognitive contextual theory
   d) Family conflict theory
2. Which of the following is NOT one of the Gottman conflict styles?
   a) The competitive style
   b) The avoidant style
   c) The volatile style
   d) The validating style
   e) None of the above
3. Which of the following is NOT one of the Thomas-Kilmann conflict styles?
   a) The competitive style
   b) The compromising style
   c) The validating style
   d) The collaborating style
   e) None of the above
4. All of the following are examples of dialectical behavioral therapy (DBT) skills EXCEPT:
   a) Interpersonal effectiveness skills
   b) Mindfulness
   c) Tolerating distress
   d) Emotional regulation
   e) None of the above
   f) All of the above

5. The goal of _________________ is to reestablish connection between family members by creating new emotional and interactive experiences.
   a) Emotion-focused family therapy
   b) The Gottman Method
   c) The Maudsley approach
   d) Bowenian family therapy
   e) None of the above

6. In _________________, couples are coached to manage their arousal and interactional patterns.
   a) The Gottman Method
   b) The Maudsley approach
   c) Emotion-focused couples therapy
   d) Structural family therapy
   e) None of the above

7. Which of the following is NOT one of the steps in the Gottman Method?
   a) Build positivity during nonconflict times
   b) Physically soothe self and partner
   c) De-escalate conflict
   d) Reduce the four horsemen
   e) None of the above

8. All of the following are aspects of emotion-focused therapy EXCEPT:
   a) Make repairs
   b) Build friendships
   c) Create a safe haven
   d) Teach constructive alternatives to ineffective patterns of interactions
   e) None of the above
Chapter 19

Domestic Violence-Focused Strategies
by Lynne M. Baker, PhD

Key Terms: domestic violence, Walker, cycle of violence, assessment, safety, worldview, the ABC’s of providing support, coping, forgiveness, marriage, reconciliation, person-centered approach, repentance, remorse, divorce, separation, self-awareness

Key Points:

• Domestic violence centers on a desire for power, control, intimidation, or coercion, and is a pattern of behavior rather than a single incident. Behavior is not exclusive to physical abuse and also includes sexual, emotional, psychological, and even spiritual abuse.

• Assessment of a client’s safety and her children’s safety is critical.

• Baker provides an “ABC” guide to help counselors as they work with Christian clients who are in domestic violence situations. The “A” stands for “Acquire knowledge (and with it understanding)” and involves the process of getting to know the client, how she views the world, her faith, and God, as well as her coping style.

• The “B” stands for “Identify blocks or barriers” and concerns becoming aware of any issues, such as specific religious beliefs concerning forgiveness or marriage, that may be keeping the client from changing her current situation.

• The “C” stands for “Clarify theological understandings” and involves investigating any misconceptions about such religious beliefs through gentle discussion.

• Forgiveness, marriage, and reconciliation are three common issues that are influenced by one’s religious beliefs, and misconceptions can contribute to the continuance of the abuse cycle.

• When working with domestic violence issues, counselors need to develop self-awareness and examine their own beliefs about such topics as forgiveness, marriage, and reconciliation.

Student Learning Objectives:
• To understand the definition and cycle of domestic violence, the Bible’s stance on it, and how to assess for a client’s safety
• To be able to describe Baker’s “ABC” process for working with women in domestic violence situations
• To comprehend the common misconceptions about forgiveness, marriage, and reconciliation that one may encounter with domestic violence and to also be aware of and examine one’s own beliefs on such concepts

Chapter Summary:

Domestic violence centers on a desire for power, control, intimidation, or coercion, and is a pattern of behavior rather than a single incident. Behavior is not exclusive to physical abuse and also includes sexual, emotional, psychological, and even spiritual abuse. The most popular way of defining this pattern or cycle of behavior are the three fairly self-explanatory stages developed by Walker in 1979: tension, explosion, and loving contrition/honeymoon period. The Bible is very clear on God’s opinion of such violent behavior, addressing multiple aspects and principles.

Firstly, Scripture provides a myriad of verses denouncing violence and being ruled by anger and corrupt speech. Instructions are also given on how spouses should treat their partners with mutual submission and love, and how responses of love should be given to others in general. Additionally, Jesus treated women in a caring, attentive way that was countercultural to the way men of his time treated women, illustrating the respect and love with which women should be treated.

Assessment of a client’s safety and her children’s safety is critical, and asking questions such as “How safe do you feel in going home?” and “What do you think might happen if…?” can be helpful. The goal is to encourage her to think about her situation and assess it for herself. One of the first steps women in domestic violence situations can take is realizing that the abuse is not their fault, as many women tend to believe that they are somehow doing something to deserve the perpetrator’s treatment. Gentle questions can be an effective way of helping her take steps towards this realization. It is also important to get to know her worldview, her faith, and how these views affect her thoughts about her current situation.

Baker provides an “ABC” guide to help counselors as they work with Christian clients who are in domestic violence situations. The “A” stands for “Acquire knowledge (and with it understanding)” and involves the process of getting to know the client, how she views the world, her faith, and God, as well as her coping style. For example, some women turn heavily to prayer and others like to have something else other than the abuse to focus on such as a routine. She may
also view God or the Bible as a strong source of comfort, or may find refuge in journaling, art, or reading inspirational stories. It is recommended to use a person-centered approach to counseling when trying to understand her world, validating her feelings, experiences, and efforts to make her relationship work, for it is likely she has never talked about her situation of domestic violence to anyone before.

The “B” stands for “Identify blocks or barriers” and concerns becoming aware of any issues, such as specific religious beliefs concerning forgiveness or marriage, that may be keeping the client from changing her current situation. Many abusers hide behind Scripture to excuse their abusive behavior, taking verses out of context and twisting them to fit their world. They may use these verses to tell the woman why she deserves the abuse, why she should forgive him no matter what he does, or why she cannot leave the marriage no matter what he does. Other times the woman uses Scripture or what she has been told by others to justify why she either deserves or must forever endure the abusive behavior. With good intentions and a desire to please God, she may believe that it is her duty to always forgive, and forgiveness means to stay in her current situation hoping one day her abuser will stop or change his behavior.

Finally, the “C” stands for “Clarify theological understandings” and involves investigating any misconceptions about such religious beliefs through gentle discussion. One should be careful to avoid criticism of the client’s thoughts and the verses she uses, and to instead help her critically examine these verses in context or any statements she believes and help her to think about them in a deeper way. Talking her into a belief or interpretation will not work, and she must come to a conclusion by herself that she can own and fully believe.

Forgiveness is a common issue for Christian women in domestic violence situations, and discussing definitions of forgiveness is a good place to start. Examining the difference between repentance and remorse is also relevant, as well as whether the client believes that forgiveness means continuing to receive abuse. It is helpful to let her know that forgiveness is a process, and do not push her towards forgiving the perpetrator, as this must be her own choice when she is ready. Marriage is another common issue, and the counselor can use gentle questioning to find out whether the client believes divorce or separation are options. It can be useful to discuss with her when she believes the covenant of marriage is broken, and whether it is broken when divorce papers are signed or when the spouse repeatedly abuses and uses violence, behaviors that are not consistent with love and God’s plan for marriage. Reconciliation may also be a common issue if the client has already left her abuser, as she may be feeling pressure from her own religious beliefs, from others, or from her abuser himself to reconcile. In general, reconciliation is often harmful and dangerous, as genuine change in these types of situations requires a long period of time. It is necessary to
discuss issues of safety with the client, including the safety of her children, if she is considering reconciliation.

When working with domestic violence issues, counselors need to develop self-awareness and examine their own beliefs about such topics as forgiveness, marriage, and reconciliation. One should investigate the origins of one’s beliefs and the original context of any relevant Scripture, being aware of how these beliefs could affect one’s counseling work in this area. Working through one’s own beliefs and asking questions will help equip one to go through this same process with a client as well, learning which questions are helpful or unhelpful. Baker, the author of this chapter, has written a book called *Counseling Christian Women on How to Deal with Domestic Violence* that may be beneficial to read as well as to recommend to clients who are in domestic violence situations and struggling with these issues.

**Pedagogical Suggestions:**

- Have students each choose an aspect of domestic violence to address using the verses and topics discussed under the biblical perspectives section of the chapter. Have them write a discussion board post, brief paper, or presentation on their topic, utilizing creativity and focusing on how this biblical perspective can influence any future counseling work with domestic violence situations.
- Have students break into pairs and role-play to practice assessing the safety of a client in a domestic violence situation. Ask them to conduct further research outside of the text on how to assess for safety and utilize this information in their role-play, if possible.
- Have students break into pairs or triads and role-play to practice using Baker’s ABC guide for working with domestic violence, then discuss their experience and thoughts on using this guide.
- Have a class or group discussion on possible beliefs future clients might have about forgiveness, marriage, and reconciliation, and how they would help such clients explore their beliefs in a non-judgmental, empathic way. Using the text or their own creativity, have students create a list of possible questions to ask that could be helpful, and think about how they would react if a client’s beliefs were different from their own.
- Ask students to cultivate self-awareness and write a paper about their beliefs on forgiveness and marriage, especially in the context of domestic violence. Ask them to use critical thinking and to ask themselves where their beliefs came from, any expectations they have related to these beliefs, and how
these beliefs could impact their future counseling work. Issues such as repentance, remorse, and reconciliation can also be examined.

Chapter 19 Quiz (25 questions):

Fill-in-the-blank
1. The three stages of the cycle of violence identified by _______________ include the building up of tension, the explosion, and a stage of loving contrition. (Walker)
2. When exploring the worldview and faith of the client in a domestic violence situation, it is important to avoid any apparent _______________. (criticism)
3. The “A” in Baker’s ABC guide stands for _______________. (acquire knowledge)
4. The “B” in Baker’s ABC guide stands for identify _______________. (blocks or barriers)
5. The “C” in Baker’s ABC guide stands for _______________ theological understandings. (clarify)
6. During the “A” stage, it is helpful to use a _______________ approach, utilizing congruence, unconditional positive regard, and empathic understanding. (person-centered)
7. During the _______________ stage, it is important to not dismiss the Scripture, ideas, and explanations offered by the client but rather explore those ideas as a process of discovery and contextual understanding. (C)
8. When discussing forgiveness, it can be helpful to explore with the client the difference between repentance and _______________. (remorse)

True/False
1. One of the most significant steps toward healing comes from the realization that domestic violence is not the fault of the victim. (T/F)
2. Significant coping mechanisms reported by women in one of Baker’s studies included maintaining a strong relationship with God and praying. (T/F)
3. Some women in domestic violence situations find it helpful to focus on something specific to continue functioning, such as a daily routine. (T/F)
4. Christian women in domestic violence situations may commonly cite “the marriage covenant is forever binding” as a reason for why they cannot leave their abusive spouse. (T/F)
5. When a client is considering reconciliation, the most important issue is the physical, mental, and emotional safety of both the client and her children. (T/F)

6. In cases of domestic violence, reconciliation is extremely difficult, often impossible. (T/F)

7. Careful examination of one’s own beliefs regarding religious concepts, including issues around forgiveness and marriage, is recommended when considering work with domestic violence. (T/F)

8. Baker wrote a book in 2010 called *Counseling Christian Women on How to Deal with Domestic Violence* that can be helpful for both counselors and clients when working through domestic violence issues. (T/F)

9. In the majority of cases, women who are or have been victims of domestic violence want to be able to tell their stories. (T/F)

**Multiple Choice**

1. Which of the following is NOT one of the driving forces behind domestic violence?
   a) Power
   b) Control
   c) Intimidation
   d) Domination
   e) None of the above

2. The ____________ stage of Baker’s ABC guide involves exploring the client’s worldview, faith, and ways of coping.
   a) A
   b) B
   c) C
   d) D
   e) None of the above

3. According to the text, Christian women in domestic violence situations may believe that forgiveness includes:
   a) Forgetting or excusing the offense
   b) Engaging in mediation
   c) Seeking reconciliation
   d) All of the above
   e) None of the above

4. According to Baker, forgiveness is best presented as:
   a) A process
   b) A magical event
   c) A one-time event
d) An event that can take place on command  
e) None of the above

5. Common beliefs and/or misconceptions that can commonly keep Christian women from leaving (or keep them returning to) abusive situations center on the following concepts EXCEPT for:
   a) Forgiveness  
   b) The concept of marriage as indissoluble  
   c) Pressure for reconciliation  
   **d) None of the above**  
   e) All of the above

6. Christian women in domestic violence situations may feel pressure to reconcile from all of the following EXCEPT:
   a) Foundational beliefs about marriage and/or forgiveness  
   b) Well-meaning friends  
   c) Members of the clergy  
   d) The perpetrator  
   e) All of the above  
   **f) None of the above**

7. Types of religious coping that can be helpful for women in domestic violence situations, according to the text, include:
   a) Journaling or letter-writing  
   b) Drawing or art  
   c) Reliance on Scripture  
   d) Prayer  
   **e) All of the above**  
   f) None of the above

8. Forgiveness topic questions that can be helpful when counseling women in domestic violence situations include all of the following EXCEPT:
   a) Exploration of the client’s experiences of forgiveness  
   b) Any expectations that may have been placed on her by others  
   c) Any concerns she may have regarding forgiveness  
   d) Any possible roadblocks that may hinder her ability to extend forgiveness  
   **e) None of the above**  
   f) All of the above
Chapter 20
Forgiveness-Focused Strategies: The REACH Forgiveness Model by Everett L. Worthington Jr., PhD, Steven J. Sandage, PhD, and Jennifer S. Ripley, PhD

Key Terms: divine forgiveness, interpersonal forgiveness, responsible self-forgiveness, Worthington, REACH forgiveness model, decisional forgiveness, emotional forgiveness, injustice gap, reconciliation, hope-focused couple therapy, lectio divina, empty chair dialogue, the Trait Forgiveness Scale, the Decision to Forgive Scale, the Transgression-Related Inventory of Motivations, stabilization, the four planks (decisions, discussions, detoxifying, devotion), leveling intervention, triangulation, detriangulation, grief, empathy

Key Points:
- Worthington created a five-step model that has been shown to be effective throughout the past two decades in a wide variety of settings. This model has been consistently examined through randomized controlled trials, is considered evidence-based, and there are myriad reasons as to why REACH is effective, including its availability to be used in both Christian and secular settings.
- Decisional forgiveness is a decision to forgive, to not act on seeking revenge, and emotions of empathy, love, or peace towards the offender are not necessary. Emotional forgiveness, on the other hand, does involve experiencing those emotions of empathy, love, and peace towards the offender.
- While the Bible does clearly address the importance of forgiveness, it does not describe how to specifically forgive.
- The “R” stands for “Recall the hurt,” and participants take turns explaining to their partners the offenses they are working to forgive.
- The “E” stands for “Emotionally replace negative with positive emotions,” and involves helping participants find new perspectives.
- The “A” stands for “Altruistic gift of forgiveness,” and participants are invited to reflect on past times they themselves were forgiven and how this made them feel.
- The “C” stands for “Commitment to the forgiveness experience,” and the commitment can be made in a variety of ways, such as writing a personal
contract, stating their commitment to another person or the group, or going through a ritual.

- The “H” stands for “Hold on to forgiveness when doubt occurs,” and encourages the commitment to decisional forgiveness even when emotional forgiveness is not present.

**Student Learning Objectives:**
- To be able to describe the types of forgiveness discussed in this chapter, as well as what forgiveness is not
- To comprehend Worthington’s REACH model of forgiveness
- To understand the intricacies of using the REACH model in psychoeducational groups, hope-focused couples therapy, and family therapy as described in the text

**Chapter Summary:**
Research has repeatedly shown, through over a thousand studies, that forgiveness leads to better physical, mental, and spiritual health. To help people move through the process of forgiveness, Worthington created a five-step model that has been shown to be effective throughout the past two decades. This model has been consistently examined through randomized controlled trials, is considered evidence-based, and there are myriad reasons as to why REACH is effective, including its availability to be used in both Christian and secular settings.

Before examining the REACH forgiveness model, it is necessary to define the different types of forgiveness. Divine forgiveness is based on God’s forgiveness of us through Jesus’s work on the cross. Interpersonal forgiveness involves humans forgiving each other, and responsible self-forgiveness involves taking responsibility for one’s offenses and forgiving oneself. Worthington’s model provides two different categories of forgiveness: decisional and emotional. Decisional forgiveness is a decision to forgive, to not act on seeking revenge, and emotions of empathy, love, or peace towards the offender are not necessary. Emotional forgiveness, on the other hand, does involve experiencing those emotions of empathy, love, and peace towards the offender.

While the Bible does clearly address the importance of forgiveness, it does not describe how to specifically forgive. Based on the exegesis of certain verses, Worthington believes that the forgiveness required of us is decisional forgiveness, rather than emotional forgiveness, although God does desire emotional forgiveness as well. Secular science tends to view forgiveness through a stress-and-coping model, where forgiveness is a possible coping response to the stress of being wronged. When offenses occur, this is said to create an injustice gap, and the
greater the offense, the greater the gap. It is also helpful to discuss what forgiveness is not, as it is often misunderstood. For example, forgiveness is not physically saying the words “I forgive you,” nor is it equivalent with reconciliation or justice.

While the REACH model of forgiveness can be used in a wide variety of settings, this chapter examined the model’s utilization in psychoeducation groups, hope-focused couples therapy, and family therapy. As mentioned previously, the REACH model is effective for both Christians and non-Christians. Christian psychoeducational groups are merely different in the language and concepts they use, such as prayers for the offender or the Scriptural reasons why one should forgive. The groups can be led by almost anyone, as the individuals partner up with someone else in the group whom they do not know and walk through most of the process by talking through it with their partner. If group work is not an option, individuals can work through the process with a therapist, or use web-based interventions or do-it-yourself workbooks that are available for free online.

The leader begins a group by asking participants to choose an offense to work through forgiving, rate their current level of forgiveness, and complete a series of self-scored questionnaires. Then the group participates in an icebreaker that also serves to bring up the topic of forgiveness, followed by a lectio divina exercise in which the leader reads relevant scriptures and each person in the group responds to the reading with a word or two. The leader explains the two types of forgiveness that will be used in the model, decisional and emotional, and also provide a list of twelve other incorrect forgiveness definitions. Participants discuss the definitions with their partners.

It is important not to push an individual towards committing to forgive if he or she is not ready or does not want to make such a commitment. The group leader is to simply offer participants an invitation to engage in decisional forgiveness. He uses an analogy by having participants stand and stretch out their hands while he talks at length about the burden of carrying around a grudge, and then instructs them to drop their arms and sit down; he explains that the relief they feel physically in this moment is an analogy for the relief and lightness they could feel when they engage in forgiveness. Then, the leader can teach the group the five steps of the REACH model, and participants will begin the work in their pairs.

The “R” stands for “Recall the hurt,” and participants take turns explaining to their partners the offenses they are working to forgive. The “E” stands for “Emotionally replace negative with positive emotions,” and involves helping participants find new perspectives. Common ways of doing this are using empty chair dialogue, imagining that the offender wrote them a letter explaining their behavior, or imagining what kind of pain the offender must have experienced in life to drive them to commit the offense. If empathy is not possible, there are other
options to work towards, such as sympathy. Next, the “A” stands for “Altruistic gift of forgiveness,” and participants are invited to reflect on past times they themselves were forgiven and how this made them feel. At this stage, individuals can revisit the questionnaire results from the beginning of the group and state how, if any, their degree of forgiveness has shifted so far. The “C” stands for “Commitment to the forgiveness experience,” and the commitment can be made in a variety of ways, such as writing a personal contract, stating their commitment to another person or the group, or going through a ritual. Finally, the “H” stands for “Hold on to forgiveness when doubt occurs,” and it can be helpful to remind participants that even if they do not feel the emotions of forgiveness, they are to hold on to their decisional forgiveness and know that the emotions are not required for it to be considered real. After completing the process, participants write personal answers to a series of twelve questions to customize their experience and complete their questionnaires for a final time so they can view their progress.

Hope-focused couples therapy is another platform in which the REACH model can be used, and is made up of two acronyms: HOPE and FREE. The acronym HOPE stands for Handling Our Problems Effectively, and FREE stands for Forgiveness and Reconciliation through Experiencing Empathy. In the hope-focused approach (HFA) to couples therapy, it can be helpful to begin by assessing the clients’ strengths, weaknesses, current struggles, and relationship patterns. Often they are not open to forgiveness at the beginning of therapy, but it can be helpful to assess interactive patterns surrounding offenses and forgiveness, both in the present and in the past. These assessments can be done through questionnaires, and the counselor then writes a report of the results to discuss with the couple.

If the couple are still emotionally struggling over an offense, stabilization is important, and teaching them coping mechanisms such as time-outs can help them learn to calm down and regulate their strong emotions more effectively. Also, talking about their experiences with forgiveness before they began their relationship with each other, including God’s forgiveness of them, and asking what God may want them to learn from such experiences can be a helpful indirect way to make progress when emotions are tense. Such an indirect approach can take months, but is often effective at spontaneously bringing about forgiveness between the two individuals. If this does not happen spontaneously and the couple desires it, the counselor can teach the REACH model to them using an example from each partner’s past before the current relationship began. Then, the model can be applied to the current issues. Forgiveness can lead to reconciliation, an act that can only happen when both parties are trustworthy. Worthington lists four planks that build a metaphorical bridge to reconciliation: decisions, discussions, detoxifying, and devotion. The planks can be discussed with the couple to help them understand this process, as well as help the counselor conceptualize progress.
Finally, the REACH model can also be applied in a family therapy setting in similar ways to the settings described previously, but with its own unique considerations. The process can begin by asking each family member to state his or her goals for forgiveness and familial relationships. Normalizing both differences and anxiety is important so that family members do not expect the counselor to give them a magical solution that everyone will agree on and cause them to no longer have conflict or tensions. Leveling interventions can be used, encouraging them to empathize with each other. Lastly, it is important to remember that once the family starts moving towards forgiveness, grief over time lost due to grudges and conflict may be experienced by the family members; it can be beneficial to help them feel empathy towards each other as they navigate through such emotions.

Pedagogical Suggestions:

• Have students discuss all the different definitions of forgiveness and what forgiveness is not, as mentioned in the text. Do they agree or disagree, and why or why not? Ask them to each write their own definition of forgiveness in their own words, and reflect on how they learned their interpretation of forgiveness.

• On pages 420-421, there is a list of things that forgiveness is not. Have students break into groups and discuss how they would respond to each one, if they had a client who held to that definition.

• Have students visit www.EvWorthington-forgiveness.com to view the forgiveness workbooks for free and to learn more about the REACH model.

• Have students break into groups and role-play to practice leading a psychoeducational group through the REACH model. Have students switch out the leader role at each new stage so that everyone gets a turn to practice leading a part of the model.

• Have students break into groups and role-play to practice either hope-focused couples therapy or family therapy with the REACH model, based on the information provided in the text.

Chapter 20 Quiz (25 questions):

Fill-in-the-blank

1. _________________ is a behavioral intention to refrain from seeking revenge and to treat an offender as a valued and valuable person. (decisional forgiveness)
2. ________________ involves emotionally replacing unforgiving emotions with positive, other-oriented emotions like empathy, sympathy, compassion, or love for the offender. (emotional forgiveness)

3. Scientifically, forgiveness is usually understood using a ________________ model. (stress-and-coping)

4. A(n) ________________ is the perceived difference between the way a person would like a situation resolved and the way it is now. (injustice gap)

5. During the E phase of a psychoeducational reach group, the leader can introduce the technique of ________________ to help group members gain a new perspective on their offenders. (empty chair dialogue)

6. The two halves of the hope-focused approach to couples counseling, as expressed in acronyms, are ________________ and FREE. (HOPE)

7. ________________ is defined as restoring trust in a relationship, which requires mutually trustworthy behavior. (reconciliation)

8. In ________________ forgiveness, God the Father forgives on the basis of the finished work of Jesus the Son’s restorative justice on the cross. (divine)

True/False
1. Person-to-person forgiveness is considered to be intrapersonal rather than interpersonal. (T/F)
2. The randomized controlled trial is considered the highest standard of empirical evidence. (T/F)
3. Forgiveness means physically saying the words, “I forgive you.” (T/F)
4. Forgiveness means reconciliation and restoring trust. (T/F)
5. Forgiveness means turning the matter over to God for divine justice. (T/F)
6. Forgiveness means accepting and moving on with life. (T/F)
7. The Bible does specify how to forgive. (T/F)
8. During the A phase of a psychoeducational REACH group, the leader asks group members to reflect on a time when they offended someone who forgave them. (T/F)
9. Clients often carry a fantasy that there may be some way for all to “get on the same page” so they will not have to manage the differences that create relational anxiety. (T/F)

Multiple Choice
1. Which of the following is NOT one of the seven findings of the meta-analysis on REACH discussed in the text?
   a) Decreases depression and anxiety and increases hope
   b) Available in Christian and secular versions
   c) It is an evidence-based practice in psychology
d) Can be applied to forgiving both others and oneself

e) **None of the above**
f) Only B and C

2. Settings in which REACH can be used include all of the following EXCEPT:
   a) Do-it-yourself workbooks
   b) Psychoeducational groups
   c) Couples counseling
   d) Family counseling
   e) **None of the above**
f) Only A and D

3. The questionnaires used in the REACH model include all of the following EXCEPT:
   a) The Trait Forgiveness Scale
   b) **The Forgiveness Readiness Scale**
   c) The Transgression-Related Inventory of Motivations
   d) The Decision to Forgive Scale
   e) None of the above

4. In a group setting of REACH, “the leader reads one of six scriptural passages about forgiveness, then whips around the group, and each member reacts with a word.” This part of the group is called:
   a) Creating a working definition
   b) **Lectio divina**
   c) Icebreaker
   d) Inviting decisional forgiveness
   e) None of the above

5. In one part of the REACH group, “the leader keeps time as pairs take turns sharing their ‘objective’ accounts of the harm.” This is known as:
   a) **The R**
   b) The E
   c) The A
   d) The C
   e) None of the above

6. When emotions are “hot” and forgiveness cannot be approached directly in hope-focused couples counseling, all of the following are ways that forgiveness can be indirectly addressed EXCEPT:
   a) Have both partners talk about offenses and forgiveness in their lives prior to their relationship.
   b) Talk about God’s forgiveness.
c) Work through offenses and forgiveness with a successful relationship in the past.

d) Ask each person to examine how he or she contributed to the presenting problem.

e) None of the above

7. Which of the following is NOT one of Worthington’s four planks in the bridge of reconciliation?
   a) Devotion
   b) Detoxifying
   c) Detriangulation
   d) Discussions
   e) None of the above

8. Which of the following is NOT one of the techniques or issues associated with using the REACH model in family therapy?
   a) Normalizing differences and anxiety
   b) Ask each family member to state his or her goals
   c) Detriangulating
   d) Facilitating grief and empathy
   e) None of the above
   f) Only A and B
Chapter 21
Shame-Focused Strategies by John C. Thomas, PhD, PhD

Key Terms: shame, guilt, shame-based identity, healthy/functional shame, unhealthy/dysfunctional shame, internalized shame, externalized shame, attunement, family of origin, knowing, genogram, the time-machine elevator, neuroplasticity, the shame box technique, the truth box technique, the “parts are parts” technique, vulnerability, self-compassion, the two-chair critic: criticized dialogue technique, the three-chair soothing: self-dialogue technique, letter techniques, the radical acceptance technique, mindfulness, mentalization, the opposite-action technique, the acting “as if” technique, spiritual formation, spiritual disciplines

Key Points:
• Shame is different from guilt in that guilt focuses on behavior, whereas shame focuses on personhood.
• There are a few different types of shame—shame-based identity, healthy or functional shame, unhealthy or dysfunctional shame, internalized shame, and externalized shame.
• Shame usually develops during one’s first few years as a result of dysfunctional attachment relationships.
• The first therapeutic task is to establish a therapeutic bond with the client.
• The second therapeutic task involves entering the client’s story.
• The third task is to recognize, explore, and label shame.
• The fourth task is processing and treating shame.
• Finally, the fifth task is spiritual formation.

Student Learning Objectives:
• To be able to describe the difference between shame and guilt, and the various types of shame
• To comprehend the origins, effects, and outcomes of shame
• To understand the five therapeutic tasks recommended by Thomas for working with clients who struggle with shame
Chapter Summary:
Shame, a “negative self-conscious emotion that shapes and maintains a person’s identity,” (Thomas, 2018, p. 438) exists in many forms, but it can often be confused with other emotional experiences, so it is important to first discuss what shame is not. The most common confusion occurs between the concepts of shame and guilt. Shame is different from guilt in that guilt focuses on behavior, whereas shame focuses on personhood. Additionally, shame is thought to emerge before language, whereas guilt does not occur until a later stage of a child’s development. Research has shown that shame contributes to psychological disorders more than guilt does.

There are a few different types of shame—shame-based identity, healthy or functional shame, unhealthy or dysfunctional shame, internalized shame, and externalized shame. While a person can feel temporary shame over an event or situation, the most pervasive and harmful type of shame is shame-based identity, expressed through “I am” statements such as “I am bad,” “I am defective,” “I am incompetent,” “I am unworthy,” or “I am unlovable.” This is an example of unhealthy or dysfunctional shame, which is always based on identity. In contrast, healthy or functional shame concerns a temporary event or weakness in character, and it can be a positive source of motivation for change. Relatedly, internalized shame concerns said weakness in character or personality, whereas externalized shame focuses on an event or situation.

Shame usually develops during one’s first few years as a result of dysfunctional attachment relationships. It can result in emotional reactions that are out of proportion to what is actually happening in the moment, and the individual who struggles with shame usually develops self-fulfilling prophecies in which his behaviors perpetuate the shame-infused beliefs he holds about himself. Most often he will construct a variety of defenses to protect himself from being known so that others will not find out how “shameful” he really is. Shame bypasses logic because it is a right-brain experience, responding to emotions rather than objective evidence and making it difficult for an individual to even recognize its presence. Most individuals are also very aversive to admitting the presence of shame, due to its nature, and therefore this is one of the most difficult issues to be treated. Thomas outlines 5 therapeutic tasks that can be beneficial when working with shame, as well as some pre-requisite work that the counselor can engage in before addressing shame work with clients. The pre-requisite work involves learning to be aware of one’s own shame, as one’s shame can usually be felt by clients if it emerges in session. It is important to work through one’s own issues surrounding personal shame, and also to remember that sometimes self-disclosure about one’s own shame can be helpful for clients as well.
The first therapeutic task is to establish a therapeutic bond with the client. The bond is critical, because those who struggle with shame believe that other people hold the same devaluing beliefs about them as they hold about themselves. The counselor should focus on attunement, empathy, presence, and reflection, and hyperfocus on being non-shaming to help the client have an experience counter to what he is expecting. This hyperfocus is necessary, as a client who struggles with shame will tend to interpret even the most innocent of words as shaming in some way, filtering everything through their shame-infused beliefs. Techniques to help with this challenge include monitoring the communication, checking in, not “talking the client out of it,” being human, and keeping no secrets. It can also help to let the client know that the usual rules of social interactions do not apply in counseling, to be prepared for the client to test you, and to let the client know ahead of time that she will probably feel shame and anxiety after opening up during a counseling session.

The second therapeutic task involves entering the client’s story. Sharing his story will help the client to come to new realizations about his life, connect with his right-brain by bringing emotions into the story, and experience being mirrored and attuned to by the counselor, a healing experience in and of itself.

The third task is to recognize, explore, and label shame. This task may involve the greatest amount of “work.” The origins and intricacies of the client’s feelings of shame are crucial, so the counselor should begin by assessing family of origin experiences including how conversations, emotions, vulnerability, expression of needs, and emotional closeness were handled. It is also important to examine what is missing, as “children feel shame when what they need to feel human is withheld” (Thomas, 2018, p. 451). Usually, attunement from the parents is what was missing for those who struggle with shame. Other techniques include genograms, eliciting and facing the shame, being aware that the client will likely have an escape plan to avoid the shame, and drawing them out anyway. Those with preoccupied attachment styles, however, usually do not need to be drawn out, as they often pour out their stories as if under pressure; it is wise to provide containment for them. Thomas presents a list of many more techniques that can also be used during this task: exploring feelings, exploring events, focusing, using journaling, using the time-machine elevator technique, listening for longings, voicing the pain, using the empty chair, finding a hole in the armor, and understanding the implications of the gospel of Jesus Christ.

The fourth task is processing and treating shame. Helping clients feel and verbalize their feelings of shame is important, building up their tolerance and ability to regulate such emotions. Cognitive and affective strategies can be useful, teaching clients that they are not what they feel and that they are capable of regulating and expressing their emotions in a healthy way. Psychoeducation on the
neuroplasticity of the brain can foster a sense of hope. One particular technique, taken from the work of Sanderson in 2015, involves having the client create a shame box and a truth box, writing down the shaming messages he believes for the shame box and countering each with a truth for the truth box. He then can participate in an impact exercise in which he writes down how the shame-infused beliefs have impacted his life. Other techniques include: the parts are parts technique, the practice of vulnerability technique, self-compassion, the meeting with Jesus technique, the two-chair critic: criticized dialogue technique, the three-chair soothing: self-dialogue technique, letter techniques, radical acceptance technique, mindfulness, mentalization, the opposite-action technique, the acting “as if” technique, the negative affect tolerance technique, the finding exceptions technique, the pros and cons list technique, setting boundaries, rebuilding a new identity, the universal limitations intervention, and enriching and using the client’s support system.

Finally, the fifth task is spiritual formation. It is wise to help the client build a biblically-based theology of the self so that he can believe not just with his mind but with his emotions, as the two tend to hold different beliefs. The counselor can then teach the client to turn to God for effective soothing, accepting his weaknesses in a healthy way. It can also be helpful to teach the client spiritual discipline strategies such as worship, prayer, and solitude, as these can be excellent ways for him to connect with God and continue the healing process.

**Pedagogical Suggestions:**

- Have each student stand up in front of the class and role-play a quick imaginary client story (1-2 mins) illustrating a type of shame, then have the rest of the class guess which type(s) of shame (or guilt) is being demonstrated.
- Have students break into pairs or triads and role-play to practice each therapeutic task described in the chapter. Each task consists of a wide variety of techniques that can be chosen, so one task could take a lot of time, if desired.
- Have students break into pairs or triads and role-play to practice the third therapeutic task, focusing on assessing the client’s family of origin and early experiences to help students learn the relevant questions to ask and how to think through the results.
- Have students break into pairs or triads and role-play to practice using the time-machine elevator technique or the shame box technique.
- Have students personally practice the shame box technique on their own as homework, followed by the impact exercise and the truth box exercise. Then
have them write a discussion board post or brief paper on their experience, how it impacted them, and their thoughts on using it in their future as clinicians.

- Ask students to personally participate in the practice of vulnerability technique as homework, choosing an experiential activity that they believe will make them feel uncomfortable. Then have them write a discussion board post or brief paper on their experience and how they could use this technique in the future with clients. Open the next class with a discussion of the exercise, if desired.

- Have a class discussion on how spiritual formation could be used with clients who struggle with shame, referencing the text but also asking students if they can think of any other ways not mentioned that spiritual formation could be incorporated to address feelings of shame.

Chapter 21 Quiz (25 questions):

**Fill-in-the-blank**

1. Healthy or functional shame is primarily ________________ based, whereas unhealthy or dysfunctional shame is identity based. (**event and character**)

2. ________________ shame is associated with one’s personality disposition and character rather than a specific situation. (**internalized**)

3. When working with shame, the third therapeutic task involves exploring, recognizing, and ________________ shame. (**labeling**)

4. ________________ refers to understanding how another feels, being in contact with another’s subjective world, and having a right-brain connection. (**knowing**)

5. Children feel ________________ when what they need to feel human is withheld. (**shame**)

6. Parental ________________ is what is often missing in the history of shame-prone clients. (**attunement**)

7. The ________________ technique involves writing down one’s shame-infused beliefs on pieces of paper and putting them in a box, followed by reflection/journaling about the beliefs while learning to tolerate feelings of shame. (**shame box**)

8. The “practice of ________________” technique involves assigning clients homework that challenges them to do an agreed-upon activity (or activities) that pushes them into the “horror zone” such as going to restaurants by oneself or speaking in public. (**vulnerability**)

9. The ____________ soothing self-dialogue technique involves having the client talk to the critic and shamed self, speaking truth and showing compassion. (three-chair)

True/False
1. Shame is behavioral focused, whereas guilt is identity focused. (T/F)
2. Guilt is considered developmentally pre-verbal, but shame is learned later. (T/F)
3. The shamed person develops behavioral patterns that are consistent with the defective beliefs about self. (T/F)
4. Shame is a right-brain experience. (T/F)
5. Often when you experience shame, so does your client. (T/F)
6. How parents regulate their child’s emotions has a profound impact on a child’s internal experience of shame. (T/F)
7. The fifth and last therapeutic task when working with shame is spiritual formation. (T/F)
8. The “meeting with Jesus” technique involves imaging a conversation with Christ (non-Christians can image a mature and wise-person). (T/F)

Multiple Choice
1. When working with shame, the first therapeutic task (bonding with the client) involves all of the following techniques EXCEPT:
   a) Hyperfocus on being nonshaming
   b) Practice attunement
   c) Check in
   d) Avoid attempting to “talk clients out of it”
   e) None of the above
   f) Only A and C
2. When working with shame, transformation through story and addressing right-brain language and connection are part of which therapeutic task?
   a) Task 1
   b) Task 2
   c) Task 3
   d) Task 4
   e) Task 5
3. Eliciting unexpressed/avoided shame and facing the avoidance is a technique used in which therapeutic task?
   a) Task 1
   b) Task 2
   c) Task 3
4. Shame-prone clients with a(n) ________________ attachment style continually pour out stories as if a water pipe exploded with the incredible force of pressure from painful emotions, and need containment more than exploration.
   a) Secure
   b) Avoidant
   c) Fearful/disorganized
   d) Preoccupied/ambivalent
   e) None of the above

5. The time-machine elevator technique and journaling are techniques that are used in which therapeutic task (when working with shame)?
   a) Task 1
   b) Task 2
   c) Task 3
   d) Task 4
   e) Task 5

6. ________________ is the process by which people make sense of the world by imaging how other peoples’ state of mind can influence behavior.
   a) Mindfulness
   b) Mentalization
   c) Radical acceptance
   d) Mirroring
   e) None of the above

7. The universal limitations intervention, rebuilding a new identity, and enriching/using the client’s support system are all techniques used during which therapeutic task?
   a) Task 1
   b) Task 2
   c) Task 3
   d) Task 4
   e) Task 5

8. The pros and cons list technique, setting boundaries, and acting “as if” are all techniques used during which therapeutic task?
   a) Task 1
   b) Task 2
   c) Task 3
   d) Task 4
   e) Task 5
Key Terms: trauma, post-traumatic stress disorder (PTSD), complex trauma (CT), safety and symptom stabilization, processing of traumatic memories, consolidation and resolution, rapport, empathic reflection, boundaries, confidentiality, intrusive reexperiencing symptoms, exposure and response prevention (ERP) techniques, relaxation techniques, mindfulness, dissociation, “parts of self” language, dissociative identity disorder (DID), containment, ideomotor signaling, Braun’s BASK model, grounding techniques, eye movement desensitization and reprocessing (EMDR)

Key Points:
• There are two types of trauma—event trauma, typically resulting in post-traumatic stress disorder (PTSD), and chronic relational trauma, typically resulting in complex trauma (CT).
• Complex trauma (CT) is considered especially severe because of the vulnerable stage during which the trauma occurs, and because it is usually at the hands of someone the child trusts, someone who is supposed to protect and love him.
• There is a three-phase process that is typically followed when working with CT, although the phases are known by different names; Gingrich refers to the first phase as safety and symptom stabilization, the second as processing of traumatic memories, and the third as consolidation and resolution.
• The first phase, safety and symptom stabilization, usually takes many years due to the relational nature of the severe trauma experienced by those with CT; this process primarily focuses on providing containment for distressing symptoms and building safety.
• The second phase focuses on processing traumatic memories, and the counselor can move towards this work when the client has learned sufficient coping mechanisms.
• The third phase emphasizes consolidation and resolution, and helping clients learn new coping strategies, as at this point they probably can no longer dissociate to the extent they could previously.
Student Learning Objectives:
- To be able to describe the unique nature of complex trauma (CT) and the concerns that can arise when working with such clients
- To comprehend the role of dissociation in complex trauma (CT)
- To understand the three phases of treating complex trauma (CT) according to Gingrich and how some of these techniques can also be helpful with post-traumatic stress disorder (PTSD)

Chapter Summary:
There are two types of trauma—event trauma, typically resulting in post-traumatic stress disorder (PTSD) and chronic relational trauma, typically resulting in complex trauma (CT). CT is considered especially severe because of the vulnerable stage during which the trauma occurs, and because it is usually at the hands of someone the child trusts, someone who is supposed to protect and love him. CT and PTSD share many of the same symptoms, but CT usually involves several more, including identity and attachment issues. In this chapter, Gingrich addresses strategies mainly used with CT, although both CT and PTSD can greatly benefit from mindfulness, grounding, ideomotor signaling and parts work. She delineates a three-phase process that is typically followed when working with CT, although the phases are known by different names. Gingrich refers to the first phase as safety and symptom stabilization, the second as processing of traumatic memories, and the third as consolidation and resolution.

The first phase, safety and symptom stabilization, usually takes many years due to the relational nature of the severe trauma experienced by those with CT. This process primarily focuses on providing containment for distressing symptoms and building safety, beginning by ensuring safety within the therapeutic relationship. Developing rapport is critical, and techniques such as empathic reflection, using appropriate genuineness and self-disclosure, having a nonjudgmental attitude, and being emotionally present can help. It is crucial that the counselor actually be a safe person by remembering that every client is unique, warning clients of any impending change, keeping appropriate boundaries, and keeping confidentiality. Working with CT is often intense and replete with crises, and therefore the counselor must always monitor his own mental health and competencies, seeking supervision or personal therapy when needed. It is also important to ask questions about others in the lives of one’s client to assess whether the client is safe from others, and that others are safe from the client, including the client herself.

Intrusive trauma symptoms can be especially distressing for clients, and containing and stabilizing those symptoms as much as possible can greatly help
with safety. Some techniques that can be beneficial include exposure therapy or prolonged exposure therapy, relaxation techniques, and mindfulness. Clients who suffer from CT also typically have rates of dissociation, defined as “compartmentalization, or disconnection among aspects of self and experience” (Gingrich, 2018, p. 475). There are helpful techniques that make use of this tendency to dissociate, such as using “parts of self” language, as most CT clients can identify with having different parts of themselves even if they do not have dissociative identity disorder (DID). Other names for working with different parts of self, whether the client has DID or not, include parts work, ego state therapy, and self-states. Viewing symptoms as attempts at coping is another technique, as well as making contact with dissociated parts, if applicable. One way of doing this is ideomotor signaling, a hypnotherapy technique in which the counselor teaches the client how to use finger signals for yes, no, and stop as a way for the dissociated parts to communicate.

The second phase focuses on processing traumatic memories. The counselor can move towards this work when the client has learned sufficient coping mechanisms, is able to ground herself, can manage her trauma symptoms between sessions, and agrees with the counselor that she is ready to begin phase two. It is critical not to ask leading questions or make suggestions, and to ask open-ended questions instead. The counselor should begin by asking the client where she would like to begin, and invite the part of self that holds the memory to allow access to it. During the process, it is necessary to keep the client connected to the here and now, which helps dissociated parts become integrated. The BASK model by Braun is one way of conceptualizing this concept. Other techniques that are beneficial for this phase include grounding techniques, pacing the trauma processing, monitoring the frequency and speed, and processing emotions.

Finally, the third phase emphasizes consolidation and resolution, and helping clients learn new coping strategies, as at this point they probably can no longer dissociate to the extent they could previously. It is also important to help clients grieve any losses, establish new and healthy relationships, and examine issues of forgiveness. EMDR (eye movement desensitization and reprocessing) is an additional treatment protocol that can be helpful for some CT clients, although for most its use is not recommended. CT clients with high levels of dissociation should not engage in EMDR, as this can make dissociative symptoms worse. Gingrich recommends using the Dissociative Experiences Scale-II, available for free online in the public domain, to assess for dissociation prior to treatment. Explicit spiritual resources such as prayer and Scripture can of course also be useful during the treatment process for Christian clients.
Pedagogical Suggestions:

- Have a class discussion, or have students write a discussion board post, on the biblical stories/verses cited in the text along with Langberg’s six principles and how they can influence future counseling work.
- Assign students to research an aspect of CT (using scholarly sources outside of the text) and create a PowerPoint presentation or paper on their chosen aspect.
- Ask students how they would go about assessing whether a client has experienced PTSD or CT.
- Have a class or group discussion on boundaries in counseling and how one could stay on top of one’s own mental health if working with CT clients.
- Have students break into pairs or triads and role-play to practice using “parts of self” language as a counselor. The “client” does not need to make up a trauma story or talk about any traumatic details since this is a phase one role-play. The purpose is simply for the “counselor” to practice using parts language out loud with a hypothetical dissociative client. Students will take turns playing the counselor.
- Ask students to brainstorm examples of open-ended questions and grounding techniques that could be used during phase two of CT treatment, as well as new coping strategies that could be learned in phase three.
- Ask students how explicit spiritual resources could be incorporated when working with CT clients.

Chapter 22 Quiz (25 questions):

Fill-in-the-blank

1. While single event trauma is most associated with post-traumatic stress disorder (PTSD), chronic relational trauma is associated with _______________. (complex trauma, or CT)
2. Gingrich refers to the first phase of CT treatment as _________________. (safety and symptom stabilization)
3. Gingrich refers to the second phase of CT treatment as _________________. (processing of traumatic memories)
4. Gingrich refers to the second phase of CT treatment as _________________. (consolidation and resolution)
5. ________________ uses finger signals as a way to communicate with parts of self of which the CT survivor may not be aware. (ideomotor signaling)
6. The BASK model, a way of conceptualizing dissociation, was developed originally in 1988 by ___________________. (Braun)

7. In phase three of CT treatment, clients need to develop new ________________, as they can no longer as easily compartmentalize an overwhelming feeling. (coping strategies)

8. _______________ has good research support for single-incident trauma but should not be used with highly dissociative clients such as those with CT. (EMDR)

9. The brief screening instrument recommended by Gingrich to screen for dissociation, particularly prior to considering EMDR, is available for free online and is called ______________________. (the Dissociative Experiences Scale-II).

True/False
1. The added complexity of complex trauma (CT) is in large part due to CT occurring during a particularly vulnerable stage of psychological development when relational attachments are formed. (T/F)

2. Recommended treatments for PTSD are primarily behavioral and cognitive behavioral techniques. (T/F)

3. CT survivors often experience PTSD symptoms along with many other symptoms. (T/F)

4. The first phase of CT treatment usually takes not months but years. (T/F)

5. Therapeutic work with CT survivors is often intense and punctuated by one crisis after another. (T/F)

6. CT survivors are usually motivated to seek counseling because of intrusive reexperiencing symptoms. (T/F)

7. Even those with CT who do not have DID often experience some degree of personality fragmentation. (T/F)

8. Grounding techniques involve engaging the senses of clients to help them stay in the present. (T/F)

Multiple Choice
1. Examples of chronic relational trauma that could result in (CT) include all of the following EXCEPT:
   a) Child physical abuse
   b) Child sexual abuse
   c) Child spiritual abuse
   d) Child neglect
   e) None of the above
   f) Only A and B
2. In addition to PTSD symptoms, those with CT also usually experience:
   a) Intense feelings of shame and guilt
   b) Impairment in identity formation
   c) Difficulty trusting people
   d) Problems with affect regulation
   e) **All of the above**
   f) Only A through C

3. Which of the following is listed as a strategy for helping the counselor be and remain a safe person during phase one CT treatment?
   a) Remember that every client is unique
   b) Warn of impending change
   c) Know your limitations
   d) Keep appropriate boundaries
   e) **All of the above**
   f) Only C and D

4. When encountering one’s limitations as a counselor during work with CT survivors, one should:
   a) Read in the field
   b) Get trauma-sensitive supervision
   c) Seek out appropriate training opportunities
   d) Refer out to an expert if necessary
   e) **All of the above**
   f) A through C only

5. Things you should warn your CT clients about include:
   a) Missing a session for a conference
   b) Putting a new picture on your wall
   c) Changing appointment times
   d) Any major issues going on in your life
   e) All of the above
   f) **A through C only**

6. Techniques that can be used during phase one of CT treatment include all of the following EXCEPT:
   a) Mindfulness
   b) Exposure and response prevention (ERP)
   c) Relaxation techniques
   d) Using “parts of self” language
   e) **None of the above**
   f) A through C only

7. Working with personality fragmentation in CT survivors often goes by a variety of names, including all of the following EXCEPT:
a) Parts work
b) Ego state therapy
c) Working with self states
d) **Fragmentation therapy**
e) None of the above

8. Indicators that it may be appropriate to begin phase two work with a CT survivor include all of the following EXCEPT:
a) When the client is able to ground herself
b) When the client is able to manage trauma symptoms between sessions
c) When the client agrees it is a good time to begin
d) **When the techniques used in phase one are not helping**
e) None of the above
Chapter 23
Nonsuicidal Self-Injury-focused Strategies by David Lawson, PsyD

Key Terms: non-suicidal self-injury (NSSI), suicidality, borderline personality disorder (BPD), cutting, shame, physical grounding, control, the silent scream, self-punishment, depersonalization, derealization, dissociation, trauma, online communities, obsessive compulsive disorder (OCD), substance abuse, systems or family therapy, cognitive behavioral therapy (CBT), psychoanalytic/relational therapy, transference, countertransference, yoga, meridian points, dialectical behavior therapy (DBT)

Key Points:
• Self-injury has a long history, as almost all religions have utilized it at some point in time for the purpose of self-punishment, purging, cleansing, or becoming more “spiritual” by harming the flesh.
• Contrary to previous beliefs, self-injury is now considered to be its own phenomenon, not a suicide attempt, and the DSM-5 refers to it as non-suicidal self-injury (NSSI).
• Self-injury is reported most often in adolescent populations, although some studies show it is also becoming common in college populations.
• There are four main reasons that tend to be behind non-suicidal self-injury: grounding, control, the silent scream, and self-punishment.
• According to Lawson, there are three treatment methods that can be helpful with self-injury: systems therapy or family therapy, cognitive behavioral therapy, and psychoanalytic/relational therapy.
• In addition to these three main treatment methods, there are a variety of other techniques that have been shown to be effective with those who self-harm, particularly intransigent cutting: yoga, meridian points, ice, rubber bands, and drawing on the skin.

Student Learning Objectives:
• To understand the diagnostic and assessment issues surrounding self-injury
• To be able to describe the most common motivations behind self-injury
• To comprehend the three main treatment methods for self-harm, as well as the additional techniques that can be beneficial
Chapter Summary:

Self-injury has a long history, as almost all religions have utilized it at some point in time for the purpose of self-punishment, purging, cleansing, or becoming more “spiritual” by harming the flesh. However, Jesus bears the scars so that we do not have to; those who struggle with self-injury may find solace in knowing that Jesus experienced wounds too, and kept his scars to show us that he understands pain.

Psychologically, self-injury was previously considered either suicidal or evidence of borderline personality disorder (BPD), two very heavy issues that therapists often tended to avoid due to their intensity. As a result, many individuals who engage in self-injury often feel very stigmatized, even by those in the mental health field, and therefore feel intense shame and a desire to hide their behavior. Contrary to previous beliefs, self-injury is now considered to be its own phenomenon, not a suicide attempt, and the DSM-5 refers to it as non-suicidal self-injury (NSSI).

Self-injury is reported most often in adolescent populations, although some studies show it is also becoming common in college populations. Females appear to engage in self-injury more than males, but this could also be due to underreporting or definition differences. People tend to believe that self-injury is driven by a desire to seek attention, a desire to commit suicide, or by borderline personality disorder as previously mentioned, and while most of the time this is not the case, it is still important to keep these issues in mind when first presented with a self-harming client. In a case where the self-harm is actually driven by a desire for attention, this is often due to borderline personality disorder. Suicide assessment both at the beginning of therapy and throughout the entire process is critical and also serves to normalize suicidality assessment, letting the client know that self-harm and suicidality are not always related. It is also essential to assess for trauma history, as this can be common among those who self-harm. Yet another area for assessment is the client’s participation in online communities such as social media sites or forums. These online communities can be a source of positive emotional support and encouragement to recover, but they can also be a source of triggers and encouragement to continue self-harming. Counselors should use open-ended questions and ask clients about their online experiences, if applicable. Counselors should consider assessing for other diagnoses as well, particularly obsessive compulsive disorder (OCD) and substance disorders; there are some who believe that self-harm is simply an expression of one of these disorders, and while sometimes it could be, often it is not, so accurate assessment is essential.
There are four main reasons that tend to be behind non-suicidal self-injury: grounding, control, the silent scream, and self-punishment. Those who self-harm for grounding purposes state that they feel disconnected from their bodies, similar to the concepts of depersonalization, derealization, and dissociation. Because they cannot feel their physical bodies, they feel as if they are dead, but cutting helps them feel alive and connected to their bodies again. Those who self-harm for control purposes usually feel their lives are out of control and use cutting as a way of regaining their sense of control. When this occurs in adolescents, the parents may be overly controlling or have overly high expectations. The silent scream refers to the expression of pain; these individuals may have difficulty expressing their emotions in words or even labeling them, and they turn to cutting as a way of releasing and communicating their pain. Finally, in the self-punishment category, those who engage in self-harm have intense emotions and thoughts, usually of shame and/or guilt, and cutting is their way of purging themselves of their “badness” by punishing themselves through pain. Also, although not necessarily its own category, some individuals engage in self-harm because the process of taking care of their wounds afterwards makes them feel loved and cared for, so it is important to assess for this dynamic as well.

According to Lawson, there are three treatment methods that can be helpful with self-injury: systems therapy or family therapy, cognitive behavioral therapy, and psychoanalytic/relational therapy. System therapy can be advantageous because of its emphasis on family pathology and how the family relationships influence the client’s own struggles with self-harm. Sometimes clients may subconsciously hold themselves back from changing out of a sense of loyalty to their family, unconsciously worried about how their recovery might affect family members. It is important to learn how the family’s relationships relate to the client’s self-harm behaviors, if at all. Cognitive behavioral therapy (CBT) is beneficial because it can help clients learn about the thoughts, emotions, and behaviors that are connected to their self-harm. Those who self-harm often think in black and white and experience very intense emotions, which is why CBT is an excellent choice. CBT can help them to be aware of maladaptive thoughts and to replace them with adaptive ones, as well as gain insight into their self-harm, for clients can be confused about why they are engaging in such behavior. Finally, psychoanalytic/relational therapy is useful because it centers on the client’s relationship with the therapist as a catalyst for healing, moving away from the past notions of drives and more towards the importance of the present relationship. In this modality, the counselor should create a “holding” environment for the client and can help clients gain insight into their relational patterns as they surface in the therapeutic relationship. As could be expected, transference and countertransference are still important concepts in this type of therapy.
In addition to these three main treatment methods, there are a variety of other techniques that have been shown to be effective with those who self-harm, particularly intransigent cutting. Yoga is particularly helpful for those who struggle to feel connected to their bodies. Meridian points, places on the body where one can press to create a sense of grounding and pain, can also be helpful for such purposes. Other techniques, borrowed from dialectical behavior therapy (DBT), include using ice, rubber bands, or drawing on the skin as ways to satisfy the urge to cut without actually cutting.

**Pedagogical Suggestions:**

- The text lists a quote by Dr. John Thomas: “The world is full of people with wounds looking for those with scars.” Ask students to reflect on the meanings and implications of these words, either in a class/group discussion or a discussion board post; how does this concept influence counseling?
- The text lists multiple reasons behind self-harm behavior. Ask students if they can think of any other possible reasons not listed.
- Ask students how they would go about assessing the reasons behind a client’s self-harm, particularly if the client claimed she did not know why she engaged in the behavior. This can be a class/group discussion or a discussion board post.
- Beyond the additional techniques listed, ask students if there are any other techniques they can think of that could be useful with different types of self-harm. Ask them to research this question and see what the literature has to say.
- Have students write their own paper on conceptualizing non-suicidal self-injury, illustrating the importance of using scholarly research and comprehensive/multiple conceptualizations. Spiritual and/or reflection sections can also be included if desired.
- Have students break into pairs and choose one of the therapies from the text to further research and teach to the class, in relation to the treatment of self-harm. They can do this through PowerPoints, role-play, or whatever creative way they choose. Have the class vote on the most creative, accurate, and helpful presentation.

**Chapter 23 Quiz (25 questions):**

**Fill-in-the-blank**

1. The four main reasons described in the literature as to why people engage in self-harm are: ____________________, (physical grounding)
2. ____________________, (control)
3. ____________________, (the silent scream)
4. and ______________________. (self-punishment)
5. The phrase “I don’t feel things in my body” would be associated with the literature-supported self-harm motivation of ________________. (physical grounding)
6. The literature-supported self-harm motivation of ________________ (the silent scream) is connected to the expression of pain; people struggle to effectively find words to describe what their lives have been like because their emotional distress seems to stifle their abilities to communicate.
7. The literature-supported self-harm motivation of ______________ (self-punishment) could involve the thought, “I am bad or did something bad, therefore I must suffer/be punished to make things right again.”
8. The strength of _____________ therapy when working with those who self-injure is found in the awareness of the connection to family as a participant in the pathology. (family or systems)
9. ________________ is a technique in which a client is directed to put pressure on the upper lip just below the nose as a way to assuage the urge to cut. (meridian point)

True/False
1. Many who engage in self-injury feel stigmatized by the mental health community. (T/F)
2. Only one or two major religions have some form of self-punitive process to help cleanse, purge, or limit the flesh’s impact on spiritual and religious life. (T/F)
3. Most prominent among all definitions of self-injury is the idea that the self-harm cannot be a suicide attempt. (T/F)
4. The greatest number of reported cases of self-harm consistently occurs during childhood. (T/F)
5. Many believe that individuals who self-injure are attention seeking or are doing it as an explicit threat of suicide, but neither of these ideas captures the actual issues of those who self-injure. (T/F)
6. Self-injurious behavior can produce the sense of being powerful and autonomous for those who feel out of control. (T/F)
7. Although some clients can describe the day and time the first self-injury incident occurred in detail, others cannot remember the details. (T/F)
8. Pairing yoga with any form of therapy when working with self-injury can be an effective way for clients to feel more grounded in their bodies. (T/F)
Multiple Choice
1. Cutting could be viewed as all of the following but is MOST COMMONLY:
   a) Suicide attempts
   b) Evidence of borderline personality disorder
   c) Its own phenomenon not associated with suicidality, BPD, or OCD
   d) Evidence of obsessive compulsive disorder (OCD)
   e) None of the above
2. Self-injury can take the form of all of the following EXCEPT:
   a) Cutting
   b) Burning
   c) Bruising
   d) Picking at one’s skin or scabs
   e) None of the above
   f) Only C and D
3. The main methods for treating self-harm, according to Lawson, include all of the following EXCEPT:
   a) Cognitive behavioral therapy
   b) Systems or family therapy
   c) Psychoanalytic/relational therapy
   d) Trauma-focused cognitive behavioral therapy
   e) None of the above
4. Which of the following is NOT one of the four ways in which psychodynamic/relational therapy sets itself apart from the traditional psychoanalytic approach?
   a) The relationship is key to the therapy.
   b) There has been a movement away from drives.
   c) There is a balance between the past and the present.
   d) The unconscious still plays a role, but only in as much as the client is confused by behaviors.
   e) None of the above
   f) Only C and D
5. The “holding” environment is mainly a part of which type of therapy?
   a) Psychoanalytic/relational therapy
   b) Cognitive behavioral therapy
   c) Systems therapy
   d) Family of origin therapy
   e) None of the above
   f) All of the above
6. Other techniques that can be helpful with self-harm include all of the following EXCEPT:
a) Meridian point
b) Yoga
c) Ice
d) Rubber bands
e) None of the above
f) Only D and A

7. The use of ice for intransigent cutting is a technique borrowed from:
   a) Cognitive behavioral therapy
   b) **Dialectical behavior therapy**
   c) Systems therapy
d) Play therapy
e) None of the above

8. Which of the following is NOT one of the dynamics that can be involved with online communities and self-harm?
   a) Normalizes the behavior/helps them feel less alone
   b) Unintentional contagion effect
c) Copycat effect
d) Encouraging one another to get well and have hope
e) **None of the above**
f) All of the above
Chapter 24

*Loss-focused Strategies* by Eric Scalise, PhD

**Key Terms:** grief, H. Norman Wright, unspeakable losses, frequent losses, gradual losses, accumulated losses, final losses, identity losses, threatened losses, mourning, Elizabeth Kubler-Ross, stages of grief, complicated grief, the Inventory of Complicated Grief, developmental trauma disorder (DTD), complex trauma, resiliency, bereavement, compassion, empathy, compathic response, Grief Pattern Inventory, instrumental orientation, intuitive orientation, blended orientation, Martin, experiential interventions, emotion-focused therapy (EFT), psychodrama, empty chair technique, rituals, equine-assisted therapy, creative-expressive therapies, life timelines, memorials collages, journaling, daily examen

**Key Points:**

- Grief is defined as a normal process of pain that occurs when one loses someone or something one values or loves.
- H. Norman Wright, an expert in the field of grief, has created a list of different types of losses: unspeakable losses, frequent losses, gradual losses, accumulated losses, final losses, identity losses, and threatened losses.
- Another famous grief expert, Elizabeth Kubler-Ross, has created a list of grief stages: (1) shock and denial stage; (2) pain and guilt stage; (3) anger and bargaining stage; (4) depression, reflection, and loneliness stage; (5) the upward turn; (6) accepting and hope stage; (7) reconstruction stage.
- Complicated grief can occur when the grieving is experienced over a long period of time with little movement towards closure, and symptoms are usually severe, such as suicidal ideation or substance abuse.
- However, one of the greatest protectors from complex trauma is the concept of resilience, defined as the ability to “bounce back” after loss or trauma.
- The Grief Pattern Inventory, developed by Martin, assesses for three basic grieving orientations: instrumental, intuitive, and blended.
- There are a wide variety of strategies that can be effective with grieving clients, including experiential interventions and emotion-focused therapy (EFT).
- Other techniques that have been shown to be effective with grief include psychodrama; the empty chair technique; rituals; equine-assisted therapy and other pet therapies (canine, feline, etc.); creative/expressive therapies; life timelines; memorials; collages; journaling; writing letters or psalms; and the
daily examen, an exercise in which one prayerfully examines the day for the influence of God’s presence.

**Student Learning Objectives:**
- To be able to describe the nuances of grief, including types, stages, and orientations
- To understand the nature of complicated grief, complex trauma, and resiliency
- To comprehend the various SITs that can be effective when working with grieving clients

**Chapter Summary:**

Grief is defined as a normal process of pain that occurs when one loses someone or something one values or loves. For healing to occur, one must work “through” grief rather than “out of” it, although this requires courage and is very difficult. When working with clients who have experienced a loss, desiring to help them in this process of working “through” it, it can first be helpful to learn about the different types of losses, the various stages of grief, and relevant issues such as complex trauma, developmental concerns with children and teens, and resiliency.

H. Norman Wright, an expert in the field of grief, has created a list of different types of losses: unspeakable losses (such as miscarriage or infertility that are not often talked about), frequent losses (losing mobility or friends due to old age or illness), gradual losses (children leaving the house), accumulated losses (medical or financial problems), final losses (a loss occurring during a late stage, such as losing a spouse after decades of marriage), identity losses (losing a sense of purpose), and threatened losses (waiting for the results of a medical test). These losses can be real, anticipated, or imagined, but they all usually result in asking the most common questions of “why?” and “why me?”

Another famous grief expert, Elizabeth Kubler-Ross, has created a list of grief stages: (1) shock and denial stage; (2) pain and guilt stage; (3) anger and bargaining stage; (4) depression, reflection, and loneliness stage; (5) the upward turn; (6) accepting and hope stage; (7) reconstruction stage. Her stages are fairly self-explanatory, and it is important to note that her stages were written for the one who is dying or experiencing the loss, not the survivors.

Complicated grief can occur when the grieving is experienced over a long period of time with little movement towards closure, and symptoms are usually severe, such as suicidal ideation or substance abuse. There are several factors that can contribute to the development of complicated grief, such as the individual being in an environment where expression of grief is not acceptable or the “mode
of the loss is considered incomprehensible, senseless, tragic, or preventable” (Scalise, 2018, p. 514), among others. A helpful instrument called the Inventory of Complicated Grief was developed in 2001 by Prigerson and Jacobs, among the first to delineate complicated grief, defining the process as having symptoms that persist for over six months along with an increased negative mood. Similar to complicated grief are the concepts of developmental trauma disorder and complex trauma, discussed in a previous chapter. This is especially relevant to children and teens who experience loss, as they have greater neurobiological activation, more intense emotions, and a decreased ability to regulate them because of their young age.

However, one of the greatest protectors from complex trauma is the concept of resilience, defined as the ability to “bounce back” after loss or trauma. Resilience is developed over time through skills related to thoughts and behaviors, and there are many factors that increase resilience such as secure relationships, self-care, and faith-integration, among others. The presence of God’s Word and Spirit are also critical, as they bring “light” into the darkness of the loss. Relatedly, it can also help to remember that the pain of loss is the evidence of love; if we didn’t love, we wouldn’t grieve, but we must choose to take the risk if we want to be fully alive.

When beginning the counseling process with those who are grieving, it is imperative to remember this phrase: “everyone has a story to tell, and everyone needs that story” (Scalise, 2018, p. 519). Helping clients to tell their story is a critical part of working with loss. While working through this process, one should be aware that there are three relevant terms—bereavement, grief, and mourning—that are similar but also different. Bereavement is the state one enters when one experiences a loss, grief is the emotional pain associated with the bereavement, and mourning is the expression of the grief. Certain qualities, such as compassion and empathy, are essential. Scalise (2018) refers to the combination of the two as displaying a compathic response, modeled after Christ’s tenderhearted compassion for us. One should also keep cultural differences in mind, as different cultures can experience or express grief in different ways.

Different people also experience and express their grief in different ways. The Grief Pattern Inventory, developed by Martin, assesses for three basic grieving orientations: instrumental, intuitive, and blended. Those with an instrumental orientation are more cognitive, and tend to seek out activities and problem-solve. Those with an intuitive orientation are more focused on emotions, experiencing them as intense and needing to express their feelings rather than problem-solve. Those with a blended orientation are a combination of both instrumental and intuitive. Assessing for the client’s grieving orientation before beginning counseling work can be very beneficial.
There are a wide variety of strategies that can be effective with grieving clients, including experiential interventions and emotion-focused therapy (EFT). Experiential interventions focus on helping clients tell their stories in experiential ways rather than simply “talking”; this can be especially helpful for children and teens who may prefer non-verbal types of expression. These methods have been shown to be highly effective and to result in significant symptoms reduction. Emotion-focused therapy (EFT), developed by Sue Johnson and Les Greenberg, is an experiential intervention that combines multiple methods from other experiential types of therapy. With a focus on the present, this therapy can be effective when working with grief, although appropriate training is necessary before its utilization. Finally, other techniques that have been shown to be effective with grief include psychodrama; the empty chair technique; rituals; equine-assisted therapy and other pet therapies (canine, feline, etc.); creative/expressive therapies; life timelines; memorials; collages; journaling; writing letters or psalms; and the daily examen, an exercise in which one prayerfully examines the day for the influence of God’s presence.

**Pedagogical Suggestions:**
- After reading the text, have students write out their own definition of grief. Share with the class or discuss in groups if desired.
- Have a group or class discussion and ask students how they might go about discerning whether a client was experiencing complicated grief.
- Ask students how grief might be experienced and expressed differently in children and adolescents.
- In the text, Scalise says, “We grieve because we love, and love often speaks of relationship—being connected to someone or something that we value and cherish. . . . People can choose to love and risk loss or simply isolate themselves with loneliness in an attempt to avoid anything painful” (p. 517). Have students discuss this quote, either as a class, in groups, or in a discussion board post, reflecting on their thoughts about it and how their view might influence their future counseling work. How might their view of love and grief/pain specifically affect their work with grieving clients?
- Ask students if they can think of any examples of how cultural differences might affect the way an individual experiences and expresses grief. See page 521 for more information on cultural considerations.
- Have students research the Grief Pattern Inventory and study the three orientations. Then have them break into pairs or triads and role-play to practice assessing a client’s grief orientation; they can use either the actual
inventory or simply ask questions, or both. Then have them practice explaining the results to the client and how this information could be helpful.

- Have students each choose one type of therapy or technique from the text and create a PowerPoint presentation to teach it to the class. Emphasize that they must use other outside scholarly sources other than just the text. Instruct them to focus on how to use the method or technique specifically with grief work.
- Have students visit the websites mentioned on page 530 of the text, which provide lots of helpful information on the Elizabeth Kubler-Ross Foundation and multiple resources for those who are grieving or helping. Students can write a summary of their website explorations and their reflections on them in a discussion board post or simply discuss them in class.

Chapter 24 Quiz (25 questions):

Fill-in-the-blank
1. Grieving _______________ the loss is the only way to heal, as opposed to attempting to work “out of” it. (through)
2. The four types of losses were delineated by grief expert _______________. (H. Norman Wright)
3. Miscarriage, infertility issues, postabortion consequences, etc. where the issues are not identified, shared, or discussed are referred to as _______________ losses. (unspeakable)
4. An array of growing medical, financial, or stress-related problems and conditions are examples of _______________ losses. (accumulated)
5. Grief expert _______________is credited with creating the stages of grief. (Elizabeth Kubler-Ross)
6. When grief remains unresolved and without reasonable closure over a significant period, it is known as _______________. (complicated grief)
7. One of the best moderators of complex trauma is the capacity for and development of _______________, also referred to as buoyancy or “bounce back” ability. (resiliency)
8. _______________ is a psychic state or condition of mental anguish or emotional suffering as a result or in anticipation of bereavement. (grief)
9. The _______________ is a time of reflection and prayer at the end of the day to allow the Holy Spirit to give wisdom and insight in “examining” the day to detect God’s presence and discern his direction. (daily examen)
**True/False**

1. Kubler-Ross’s model does not address the stages of grief for survivors but for the person dying, although similarities exist. (T/F)
2. Complex trauma results in a protracted overactivation (sensitized neural responses) of an individual’s autonomic nervous system. (T/F)
3. During the process of complicated grief, secondary loss, or loss of control, actually rarely leads to increased control behaviors. (T/F)
4. In the text, bereavement, grief, and mourning are considered to be interchangeable terms for the same concept. (T/F)
5. Experiential work with grief includes constructing a world of meaning through narrative storytelling, therapeutic writing, metaphorical language, and visualization. (T/F)
6. The empty chair technique involves utilizing elements of theater such as dramatization and role-playing to reenact real-life and past situations in the present. (T/F)
7. Music is experienced in all areas of the brain and can have a profound and positive impact on neurological functioning. (T/F)
8. Animal-assisted therapies can be helpful with grief work by increasing levels of oxytocin, a bonding hormone that has a calming effect. (T/F)

**Multiple Choice**

1. The loss of children to graduation, marriage, and other empty-nest events are examples of:
   a) Frequent losses  
   b) **Gradual losses**  
   c) Accumulated losses  
   d) Final losses  
   e) None of the above

2. When the griever becomes more functional and seeks new and realistic solutions to life and problems posed, this is known as which stage of grief?
   a) Accepting and hope stage  
   b) **Reconstruction stage**  
   c) The upward turn  
   d) Anger and bargaining stage  
   e) None of the above

3. The Inventory of Complicated Grief was developed by:
   a) Kubler-Ross  
   b) H. Norman Wright  
   c) **Prigerson and Jacobs**  
   d) Perper and Lobb
4. All of the following are contributors to resilience, according to the text, EXCEPT:
   a) A positive outlook
   b) The presence of caring relationships
   c) The ability to set reasonable goals
   d) Impulse control
   e) **None of the above**
5. Which of the following is NOT one of the counselor qualities mentioned by Scalise as important when working with grieving clients?
   a) Compassion
   b) Empathy
   c) **Unconditional positive regard**
   d) A compathic response
   e) None of the above
6. The Grief Pattern Inventory was developed by:
   a) Prigerson and Jacobs
   b) Perper and Lobb
   c) **Martin**
   d) Kubler-Ross
   e) None of the above
7. When most grief “energy” is focused on problem-solving and planned activities as an adaptive strategy, this is known as which grief orientation?
   a) **Instrumental**
   b) Intuitive
   c) Blended
   d) Activity-based
   e) None of the above
8. Which of the following is NOT one of the techniques for grief work mentioned by Scalise in the text?
   a) Memorials
   b) Life timelines
   c) Collages
   d) Journaling
   e) **None of the above**
Chapter 25
Sexual Addiction-Focused Strategies by Mark. R. Laaser, MDiv, PhD

Key Terms: Pat Carnes, sexual addiction, pornography, unmanageability, neurochemical tolerance, erototoxins, dopamine, serotonin, oxytocin, vasopressin, adrenaline, endorphins, glucose, catecholamines, escalation, medication, mirror neurons, the Sexual Addiction Screening Test (SAST), David Delmonico, the Sexual Dependence Inventory (SDI), masturbation, authority rape, the sexual addiction cycle, invasion trauma, neglect, addiction interaction disorder, Ginger Manley, abstinence contract, yada sex, Virginia Satir, iceberg model, post-traumatic growth (PTG), fantasy inventory

Key Points:
- Although there are a wide variety of definitions, one of the pioneers in the sex addiction field, Carnes, has provided a useful list of five characteristics to describe the nature of sexual addiction: unmanageability, neurochemical tolerance, escalation, medication, and sex as a reward.
- When working with sexual addiction, accurate assessment is essential. There are two specific instruments that have been created for this purpose: the Sexual Addiction Screening Test (SAST) and the Sexual Dependence Inventory (SDI).
- There are four basic beliefs found among sex addicts: (1) I am a bad, unworthy person; (2) If you knew me, you would hate me and leave me; (3) No one will take care of my needs but me; and (4) Sex is my most important need.
- The sexual addiction cycle, created by Carnes, begins with trauma, either invasion trauma or neglect, which produces shame-filled core beliefs about the self. Then “preoccupation” or fantasy begins, in which the individual becomes preoccupied with sexual thoughts. Rituals follow, which involve the individual preparing to act out sexually. The acting out stage is self-explanatory, followed by the stage of despair, which drives the individual to repeat the cycle all over again in an effort to cope with feelings of shame.
- Concerning SITs that are effective with sexual addictions, in addition to the clinical interview, Ginger Manley created a model of healthy sexuality consisting of five dimensions: physical, behavioral, relational, emotional, and spiritual.
Student Learning Objectives:

- To be able to describe the five characteristics of sexual addiction, as well as the cycle of sexual addiction and the two main screening instruments used to measure sexual addiction in clients
- To comprehend the core beliefs and cognitive distortions associated with sexual addiction
- To understand the various SITs described by Laaser in each of the five dimensions of healthy sexuality

Chapter Summary:

Pornography use is considered to be a widespread issue, with male use estimated at 50-66 percent and female use at 25-33 percent; it is especially increasing among those in the Christian population, possibly due to individuals being raised in strict religious homes. Although there are a wide variety of definitions, one of the pioneers in the sex addiction field, Carnes, has provided a useful list of five characteristics to describe the nature of sexual addiction: unmanageability, neurochemical tolerance, escalation, medication, and sex as a reward.

Unmanageability is the idea that the individual feels he cannot control his behavior. This is similar to the first step in Alcoholics Anonymous, where it is admitted that one’s life has become unmanageable due to the addiction. Individuals may be angry with God for not “taking away” their desire for sinful activities, believing that if they could just stop engaging in the activities their problem would be fixed, although this is not the case. Neurochemical tolerance means that over time the brain becomes tolerant of the chemicals released during sexual activities such as pornography use or fantasy, chemicals that mimic the effects of heroin and addictive drugs; some studies even suggest that this is even more powerful than the effects of addictive drugs. Neurochemicals involved in this process include dopamine, serotonin, oxytocin, vasopressin, adrenaline, endorphins, glucose, and catecholamines. These chemicals are sought after either to calm or excite the brain. Escalation is the idea that the more one engages in the addiction, the more one engages in the addiction. Frequency increases with a kindling-like effect, and the individual has to increase the intensity of stimuli being used in order to get the same effect due to neurochemical tolerance; an example of this would be progressing from basic pornography to illegal pornography with children and adolescents. Medication is the idea that the individual uses the addiction to cope with distress, either by seeking to calm down or to create a high of pleasure, using the sexual stimuli to escape from their painful or out of control emotions. Finally,
sex can be considered a reward, as many who are addicts feel that sex is one of their basic needs in life and they are entitled to it either to simply survive or as a reward for abstaining from it for a certain amount of time.

When working with sexual addiction, accurate assessment is essential. There are two specific instruments that have been created for this purpose: the Sexual Addiction Screening Test (SAST) and the Sexual Dependence Inventory (SDI). Created by Carnes, the SAST is the most convenient and useful, as it is only 25 questions and available for free online. Also developed by Carnes, along with David Delmonico, the SDI consists of over 500 questions and is expensive. Simply asking the client questions such as “When did you choose sex as a solution to your emotional pain?” is also essential. To help organize the results of assessments and interviews, Carnes provided three levels of sexual activities to consider, although he later updated to ten types. Level one includes activities such as masturbation and fantasy, level two illegal activities, and level three actual sexual offenses such as incest and sexual harassment.

The counselor should also assess throughout the counseling process for the client’s underlying beliefs and cognitive distortions. There are four basic beliefs found among sex addicts: (1) I am a bad, unworthy person; (2) If you knew me, you would hate me and leave me; (3) No one will take care of my needs but me; and (4) Sex is my most important need. These beliefs address the areas of self-image, relationships, needs, and sexuality. Cognitive distortions that are common include Nothing will help, I can stop if I really wanted to, I just need to control it better, and It really doesn’t hurt anyone.

Being knowledgeable about the sexual addiction cycle and the role of trauma in sex addiction is also important. The sexual addiction cycle, created by Carnes, begins with trauma, either invasion trauma or neglect, which produces shame-filled core beliefs about the self. Then “preoccupation” or fantasy begins, in which the individual becomes preoccupied with sexual thoughts. Rituals follow, which involve the individual preparing to act out sexually. The acting out stage is self-explanatory, followed by the stage of despair, which drives the individual to repeat the cycle all over again in an effort to cope with feelings of shame. One should keep in mind that many of those with sexual addictions also engage in other addictions, with alcohol addiction being the most common. It is not uncommon to turn to another addictive behavior in an attempt to cope with the shame as well. In addition to assessing for other addictions, one should also assess for other mental health disorders. ADHD is the most common co-occurring mental health disorder among those with sexual addictions.

Concerning SITs that are effective with sexual addictions, in addition to the clinical interview, Ginger Manley created a model of healthy sexuality consisting of five dimensions: physical, behavioral, relational, emotional, and spiritual.
Laaser uses these five dimensions to guide the treatment process using a multifactorial, comprehensive approach.

The physical dimension includes techniques such as the abstinence contract, teaching yada sex, referring to sex therapists, and medical interventions. The abstinence contract is a way for a client to commit to sobriety from any sexual activity for a certain period of time, in order for the brain to detox. Detox can occur in seven to twenty-one days, but ninety days is recommended for an abstinence contract so that the client has sufficient time to work through issues in therapy and in his marriage, if applicable. Yada sex, for married clients only, helps them to develop deeper spiritual and emotional intimacy with their spouse. Often sex addicts experience sex as purely physical, but the concept of yada sex teaches them to experience it multidimensionally, the way God intended it. If specific sexual disorders are present, such as those listed in the DSM-5, a referral to a sex therapist may be warranted, particularly if the counselor is not trained in these issues. Referral to an inpatient or intensive outpatient program should also be considered if issues are severe, life-threatening, or outpatient counseling is ineffective. Medical interventions may also be necessary if physical issues are contributing to sexual problems, such as the presence of STDs and nutritional deficiencies.

The behavioral dimension includes support groups, accountability, and commitment to recovery programs. Support groups such as Sexaholics Anonymous, SexAddicts Anonymous, and Sex and Love Addicts Anonymous follow the same twelve-step process as Alcoholics Anonymous and can be highly effective components of treatment. Accountability, which can also be found in such groups or elsewhere, is critical; the accountability process must not simply focus on “not doing” the addictive behaviors but must also focus on creating positive behaviors to replace them. Furthermore, the individual needs not one accountability partner but many, which is why groups are so beneficial. Whatever recovery program the individual has chosen, he must also commit to it, and understand that it is a lifelong commitment, not a temporary one.

The relational dimension consists of couples’ counseling (for those who are part of a couple) and managing disclosure. The spouses should also receive help through their own counseling and/or support groups, as talking with others who have been through the same experience is very helpful. Spouses should also be told that their partner’s infidelity and addiction is not their fault, as they are often blamed or blame themselves. The addict must also disclose to his spouse about the addiction and where he is at in his recovery in order to re-build trust, although graphic details should be left out. One helpful tool for this is Virginia Satir’s iceberg model, which helps individuals examine their emotions, perceptions, expectations, and yearnings beneath their behaviors.
The emotional dimension focuses on reclaiming thoughts and fantasy, fantasy inventory, and healing communities. As trauma is often involved with sexual addiction, it is important to grieve the trauma and work through the process to post-traumatic growth, which happens through the changing of one’s thoughts. Clients can learn to reclaim their thoughts and fantasy life by learning to control them. A fantasy inventory is one way of doing this, involving examining the fantasies in detail and asking what they are trying to say. Fantasies can often be the brain’s way of trying to heal something from the past, so details are critical for achieving such insight. Community is also important, and can meet many of the unmet needs that were driving the addiction.

Finally, for the spiritual dimension, Laaser lists seven goals that one can use with clients to help them through the spiritual aspect of their recovery. The first goal is for the client to be willing to change, followed by discovering what the client is truly searching for in his life. The next few goals are for the client to become sacrificial, to develop a daily meditation program, and to develop a theology of suffering. Lastly, the client should cultivate an attitude of forgiveness and develop a vision for his life.

**Pedagogical Suggestions:**

- **Class or group discussion:** The text states that repressive religious homes may be one reason for the high percentages of Christians using pornography. What might other reasons be? What might other reasons for pornography addiction in general be that are not mentioned in the text?
- **Have students go to Dr. Carnes’s website and become familiar with it and the resources he offers:** www.sexhelp.com. Then, have them obtain a copy of the Sexual Addiction Screening Test available for free on the website and become familiar with the questions and how to score it. If desired, have them break into pairs and practice explaining hypothetical results of this questionnaire to a hypothetical client in a tactful way.
- **Have students brainstorm ways to assess for and address the common core beliefs and cognitive distortions involved in sexual addiction.** This could be a class/group discussion or discussion board post.
- **Have students research and compile a list of support groups or other services for sexual addiction in the area (or the area in which they plan to practice therapy in the future) so that they are aware of which kinds of services are available for future clients. They may also research intensive outpatient or inpatient services for sexual addiction.
- **Have students each choose a topic from the chapter and engage in further research, creating a PowerPoint presentation, paper, or discussion board post**
on their findings to teach the rest of the class. Students should use sources other than the text that are scholarly and peer-reviewed.

- The text discusses helping clients develop vision and mission statements for their lives. Have students break into pairs and practice walking each other through the process of creating these statements as practice.
- Have students research Virginia Satir’s iceberg model, then break into pairs and role-play to practice teaching this model to a client and using it in a hypothetical therapeutic context.

Chapter 25 Quiz (25 questions):

Fill-in-the-blank

1. The five characteristics of sex addiction, according to Carnes, are __________________, (unmanageability)
2. __________________, (neurochemical tolerance)
3. __________________, (escalation)
4. __________________, (medication)
5. and __________________, (sex as a reward)
6. The Sexual Addiction Screening Test is available for free online on Dr. Carnes’s website __________________. (www.sexhelp.com)
7. Masturbation, pornography, fantasy, prostitution, and affairs are considered level _________ of Carnes’s nonprogressive levels of sexual addiction. (one)
8. There are two kinds of trauma/abuse: invasion and ______________. (abandonment or neglect)
9. The most frequent comorbid condition for sex addiction is ___________. (ADHD)

True/false

1. Common for addicts is the belief that not acting out or sinning is the answer to the problem. (T/F)
2. Research suggests that pornography triggers chemicals in the brain that create a euphoric experience similar to that of heroin. (T/F)
3. The brain is so charged by sex that adrenaline is both released and increased with sexual thoughts such as fantasy. (T/F)
4. Often addicts unwittingly or intentionally shut down oxytocin release to avoid bonding with any sexual partner. (T/F)
5. The most common form of escalation in sexual addiction is to graphic underage material. (T/F)
6. Early in their acting out, addicts learned that without sex they feel like their basic needs are unmet. (T/F)
7. Addicts can remain sober with only one accountability partner. (T/F)
8. In sex addiction treatment, ask clients to tell you about their fantasies, but let them know that details should always be avoided. (T/F)

Multiple Choice
1. Which of the following is NOT one of the neurochemicals listed as being involved in sex addiction tolerance?
   a) Dopamine
   b) Oxytocin
   c) Vasopressin
   d) Adrenaline
   e) None of the above
   f) Only A and B
2. Which of the following is NOT one of the screening instruments for sexual addiction mentioned in the text?
   a) The Sexual Addiction Screening Test (SAST)
   b) The Sexual Addiction Inventory (SAI)
   c) The Sexual Dependence Measure (SDM)
   d) The Sexual Dependence Assessment Protocol (SDAP)
   e) None of the above
   f) B through D
3. All of the following are listed as core beliefs associated with sexual addiction EXCEPT:
   a) I am a bad, unworthy person.
   b) If you knew me, you would hate me and leave me.
   c) No one will take care of my needs but me.
   d) If I do not engage in sexual activities, I will die.
   e) None of the above
4. All of the following are stages in the sexual addiction cycle EXCEPT:
   a) Preoccupation or fantasy
   b) Rituals
   c) Acting out
   d) Despair
   e) None of the above
   f) Only C and D
5. The most common co-addiction with sex addiction is:
a) Cocaine  
 b) Heroin  
 c) Alcohol  
 d) Gambling  
 e) None of the above

6. Which of the following is NOT one of Ginger Manley’s five dimensions of healthy sexuality?
   a) Physical  
   b) Biological  
   c) Emotional  
   d) Relational  
   e) None of the above

7. The abstinence contract is a part of which dimension of healthy sexuality in sex addiction treatment?
   a) Physical  
   b) Biological  
   c) Emotional  
   d) Spiritual  
   e) None of the above

8. Which of the following is NOT one of the seven goals listed to help you assist your clients with spiritual formation during sex addiction treatment?
   a) Develop a theology of suffering.  
   b) Determine what the addict is truly searching for in his life.  
   c) Cultivate an attitude of forgiveness.  
   d) The addict must become entirely willing.  
   e) None of the above  
   f) Only C and D
Chapter 26

Infidelity-Focused Strategies by Michael Sytsma, PhD, and Douglas Rosenau, EdD

Key Terms: infidelity, unfaithfulness, wounded spouse, offending spouse, affair partner, self-of-the-therapist, inception, pre-discovery, discovery, recovery, resolution, complex trauma, post-traumatic stress disorder (PTSD), grief, expectations, hope, risk assessment, structured separation, modeling, active listening, systemic understanding, second-order change, sexually transmitted infection (STI), penance, punishment, resolution phase, relapse prevention

Key Points:

- Infidelity is defined in this chapter as any type of unfaithfulness.
- There are several relevant concepts that counselors should be aware of when working with infidelity: the competence of the self-of-the-therapist, the complexity of infidelity, the complex trauma involved in infidelity, and the view of infidelity as sin.
- There are some specific strategies recommended for the first three sessions when working with infidelity; the first session should be with the couple, the second with the offending spouse, and the third with the wounded spouse.
- After these first three sessions, some general SITs that can be beneficial include setting expectations for healing, providing hope, risk assessment/structured separation, laying out the “rules,” and modeling/active listening.
- Other SITs include healing the wound before attacking the disease, rebuilding trust/full disclosure, penance and examining roles, rebuilding sexual intimacy and examining the possibility of an STI, and resolution/relapse prevention.

Student Learning Objectives:

- To be able to describe the relevant concepts counselors should be aware of when working with infidelity
- To comprehend how to conduct the first three sessions with a couple facing infidelity
To understand the various SITs described in this chapter that are beneficial when working with infidelity

Chapter Summary:
In 1989, infidelity, defined in this chapter as any type of unfaithfulness, was listed as the number one reason for divorce in 160 countries. Today, it seems to still be fairly common, and younger women and men appear to engage in infidelity at the same rate. Some statistics suggest that 65 to 70 percent of those who have this experience choose to stay married, however, and good therapy may be significant in helping couples through this type of trauma. There are several relevant concepts that counselors should be aware of when working with infidelity: the competence of the self-of-the-therapist, the complexity of infidelity, the complex trauma involved in infidelity, and the view of infidelity as sin.

Working with infidelity can involve lots of painful emotions and erotic details that can be difficult to tolerate; it is critical that the counselor be able to tolerate such dynamics in order to help clients tolerate them as well. It is also critical for the counselor to become educated on infidelity-related therapy as well as the common phases of the infidelity process: inception, pre-discovery, discovery, recovery, and resolution. The counselor should also be aware that infidelity is complex and can occur in a wide variety of ways, not only sexually. Infidelity can also cause complex trauma, and some research has shown that many wives who have been betrayed developed symptoms of post-traumatic stress disorder (PTSD). Grief is also a part of the process for both the wounded and the offending spouse, and clients must move through the stages of grief, a process that can take not months but years. The counselor should also remember that according to Scripture, infidelity is a sin, an offense against God and against the spouse.

There are some specific strategies recommended for the first three sessions when working with infidelity. The first session should be with the couple rather than just one of the spouses, as this lets both individuals know they cannot attempt to form an alliance with the counselor against their spouse. In this first session, the wounded spouse tells his or her story, and even if the offending spouse tries to interject, respectfully draw the attention back to the wounded spouse’s story. The second session should be with the offending spouse, letting him or her unpack the affair. The third session should be with the wounded spouse, letting him or her process the pain as the counselor assesses how committed the wounded spouse is to the marriage and what he or she knows about the actual affair.

After these first three sessions, some general SITs that can be beneficial include setting expectations for healing, providing hope, risk assessment/structured separation, laying out the “rules,” and modeling/active listening. Many couples
have unrealistic expectations about healing and the length of time it will take, so it is important to let them know from the beginning that the healing process typically takes three to five years. It is wise to also let them know that the offending partner will probably heal first, and the wounded partner will generally need more time, but complete healing is possible, even though life will be different. This can lead into providing hope for the couple, and helping them recognize ways in which they have cared for each other even in the midst of the trauma can be beneficial. The counselor should also assess for any safety risks, as infidelity is one of the most prominent factors in marriage violence.

Structured separations can be helpful or necessary if violence is suspected or simply if the couple really needs some space for the emotions to settle. Whether separated or not, one of the most effective strategies for couples involves laying down the “rules” which can help them feel more stable, hopeful, and protected. The first rule is that there must be absolutely no contact with the affair partner. The second rule is to be truthful in all things, especially if the affair partner does make contact, and the offending partner must immediately stop the communication and involve the spouse to restore a sense of control and honesty. Regardless of the SITs used, modeling and active listening should be utilized by the counselor throughout therapy; many couples simply lack the skills of active listening, and learning them in counseling is a very helpful strategy for strengthening their relationship.

Other SITs include healing the wound before attacking the disease, rebuilding trust/full disclosure, penance and examining roles, rebuilding sexual intimacy and examining the possibility of an STI, and resolution/relapse prevention. It can be easy to focus on the “why” of the infidelity and to get sidetracked or stuck rather than focusing on the issue at hand—healing the marriage. One strategy the counselor must employ is to ensure this does not happen by helping the couple stay focused on the goal. Rebuilding trust is a part of that goal, and it involves the wounded spouse learning to trust and the offending spouse being completely open and transparent as a way of learning to be trustworthy. The offending spouse should engage in full disclosure, or confession, of the infidelity as one way of doing this. It is better to disclose all the information at one time, rather than in pieces over time, and to focus on the process rather than the details so as not to unnecessarily further traumatize the wounded spouse. Healthy penance, as opposed to punishment, on the part of the offending spouse can also help with rebuilding trust. Examining their roles can be helpful as well; for example, the wounded spouse may be falling into the role of detective or the offending spouse may be falling into the role of defensive blamer.

Additionally, one of the most effective strategies is to help the couple rebuild sexual intimacy. Part of this does include acknowledging the possibility of an STI and getting the proper tests, if sexual infidelity occurred, as most STIs can have no
symptoms. The couple should also attend to the trauma, make needed changes, and find new meaning in their sex life. For example, it can be helpful to ask the couple what they would like to express through their sexual intimacy with each other. Eventually, couples will be able to enter the resolution phase. In this phase, the couple should monitor themselves for any signs of a potential relapse while continuing to prioritize their intimacy and their marriage.

Pedagogical Suggestions:

- On page 559, the authors list common myths that counselors believe about infidelity. Discuss these myths in a class/group discussion, asking students to share their thoughts on these myths and their own beliefs about infidelity. This can also be a discussion board post.
- Ask students to reflect on and discuss the question “What are some ways a counselor could provide hope while also managing realistic expectations for a couple who has experienced infidelity?”
- In practice, how might one differentiate penance from punishment in regards to infidelity? Ask students to discuss this question either in groups or discussion board posts.
- Have students each choose one topic from the text to further research and create a PowerPoint, paper, or demonstration to teach the rest of the class. The standard rules for using scholarly, academic sources apply.
- In regards to infidelity, the text mentions that “hearing the stories can be very painful to highly erotic for the counselor” (p. 559). Have students reflect on their ability to tolerate such intense emotions in a counseling room, how this might affect their future work with clients facing infidelity, or how they might improve their abilities in this area if they desire to work with infidelity someday.

Chapter 26 Quiz (25 questions):

Fill-in-the-blank

1. When establishing the “rules” for the couple after infidelity, the first rule is ________________________________. (absolutely no contact with the affair partner)

2. When establishing the “rules” for the couple after infidelity, the second rule is ________________________________. (be truthful in all things)

3. When confessing or giving a full disclosure of infidelity, the offending spouse should focus on ________________ rather than details. (process)
4. As opposed to punishment, _____________ can mean investing time, money, and energy to rebuild the marital intimacy that has been so damaged by infidelity. (penance)

5. After counseling for infidelity, avoiding conflict and stockpiling anger can be a warning sign that the couple is in danger of ______________. (relapse)

6. One strategy for infidelity discussed in the text is to focus on ____________ (healing) the wound before attacking the ____________. (disease)

7. The most important core concept is the recognition of infidelity as a kind of complex ______________. (trauma)

True/False

1. Infidelity can also be defined as a fantasy. (T/F)
2. According to research, very few wives have responded to disclosure of infidelity with post-traumatic stress disorder (PTSD) symptoms. (T/F)
3. The normal healing process after infidelity is about 1 to 2 years. (T/F)
4. The wounded partner will typically heal long before the offending partner. (T/F)
5. Infidelity is one of the leading causes of violence in marriage. (T/F)
6. Keeping the couple focused on the current wound is a strategy that our experience has shown facilitates a more complete healing. (T/F)
7. Sexually transmitted infections are rarely asymptomatic. (T/F)
8. Trickle disclosure is the most helpful kind of disclosure. (T/F)
9. Infidelity is varied and complex. (T/F)

Multiple Choice

1. Which of the following is NOT an example of infidelity?
   a) Addictive/compulsive sexual acting out
   b) Brief or more casual sexual hookups
   c) Online romantic relationships
   d) Emotional affairs that never culminate in physical sex
   e) None of the above
   f) Only A and B

2. Which of the following is NOT one of the phases of infidelity?
   a) Inception
   b) Pre-discovery
   c) Discovery
   d) Pre-recovery
   e) None of the above
3. The first session when working with infidelity should be with:
   a) The offending spouse
   b) The wounded spouse
   c) The couple
   d) The affair partner
   e) None of the above

4. The second session when working with infidelity should be with:
   a) The offending spouse
   b) The wounded spouse
   c) The couple
   d) The affair partner
   e) None of the above

5. The third session when working with infidelity should be with:
   a) The offending spouse
   b) The wounded spouse
   c) The couple
   d) The affair partner
   e) None of the above

6. Which of the following is NOT one of the strategies mentioned in the text for working with infidelity?
   a) Rebuilding trust
   b) Guide a full disclosure (confession)
   c) Healthy penance
   d) Helping them choose their role
   e) None of the above
   f) Only A and C

7. For the wounded spouse, common corrosive roles can include all of the following EXCEPT:
   a) The detective
   b) The accountability partner
   c) The manager
   d) The insurance agent
   e) C and D
   f) A and D

8. For the offending spouse, common corrosive roles can include all of the following EXCEPT:
   a) The defensive blamer
   b) Guilt-ridden “infidel”
   c) Impatient victim
   d) Happy camper
Chapter 27

Betrayed Spouse-Focused Strategies by Debra Laaser, LMFT

Key Terms: the trauma model, twelve-step model, codependent/co-addict, post-traumatic stress disorder (PTSD), post-traumatic growth (PTG), relationship betrayal, genogram, trust, sexually-transmitted disease (STD), space/separation, the ampersand, black and white thinking, anger, sexual addiction, truth, boundaries, bottom lines, accountability partners, safe community, distorted beliefs, cognitive restructuring, forgiveness, vision

Key Points:

- Often women are told they are codependents or co-addicts who need to work on themselves or powerless victims of trauma, one extreme or the other. Laaser states that both of these approaches are counterproductive, and instead advocates for a post-traumatic growth (PTG) model in which women are able to express their pain without learning to feel like powerless victims.

- Laaser states that firstly clients need to be able to express their pain, tell their story, and be heard and validated immediately, and thus lets them do this in the very first session instead of asking various assessment questions.

- Laaser recommends that the second and third sessions be guided by the client, empowering her to initiate talking about whatever she needs and desires to talk about.

- Timing is imperative, and encouraging a woman to “work on” herself at the wrong time can be damaging. Often counselors do this too quickly. It must be done at the right time and in the right way, empowering her to make choices for a better life rather than making her feel like she is at fault for her husband’s infidelity.

- There are many topics that Laaser addresses at various points in the counseling process: physical health, needing space/separation, making decisions, the roller coaster ride, the ampersand, managing anger, education about sexual addiction, living in the truth, rebuilding trust, boundaries and bottom lines, accountability partners, safe community, reframing distorted beliefs, knowing whether to stay or leave, forgiveness, and overriding old associations.
Student Learning Objectives:
- To be able to describe the common approaches to counseling betrayed women and why they are not typically effective
- To understand Laaser’s recommendations for the first three sessions with a betrayed woman
- To comprehend the various helpful topics to be discussed during the counseling process with a betrayed woman, as recommended by Laaser

Chapter Summary:
This chapter focuses on women who have been betrayed in marriage by the infidelity of their spouse. Unfortunately, many women are counseled in unhelpful or even damaging ways; often they are told they are codependents or co-addicts who need to work on themselves, or powerless victims of trauma, one extreme or the other. Laaser states that both of these approaches are counterproductive, and instead advocates for a post-traumatic growth (PTG) model in which women are able to express their pain without learning to feel like powerless victims.

While there are not particular SITs that can be methodically applied to every woman’s situation, Laaser recommends several general guidelines that have been shown to be effective in her experience. She states that firstly clients need to be able to express their pain, tell their story, and be heard and validated immediately, and thus lets them do this in the very first session instead of asking various assessment questions. She also states that it is imperative to let clients know immediately that their husband’s infidelity was not their fault. Additionally, Laaser asks clients if they have any safe people in their lives they can talk to who can also be impartial. She describes characteristics of safe people to the client, and suggests joining a support group of other women who have also experienced being betrayed. Often women have been told they are “crazy” and have learned not to trust themselves or the Holy Spirit inside of them, accustomed to their experience being invalidated. It is important for the counselor to talk to the client about trusting herself (and the Holy Spirit), acknowledging how this is difficult for her because others, including her husband, did not validate her reality. The counselor can provide a healing place for her by validating her experiences and assuring her that she is actually not “crazy.” Inquiring about whether her husband is seeking help and providing words on hope are also necessary components of the first session.

Laaser recommends that the second and third sessions be guided by the client, empowering her to initiate talking about whatever she needs and desires to talk about. A five-question check-in is suggested, in which the counselor can obtain a lot of useful information about the client’s self-care and the way she sees
herself. Genograms and learning about the client’s early life experiences are also useful, although this information is meant to bring insight rather than focus the sessions on the past. Timing is imperative, and encouraging a woman to “work on” herself at the wrong time can be damaging. Often counselors do this too quickly. It must be done at the right time and in the right way, empowering her to make choices for a better life rather than making her feel like she is at fault for her husband’s infidelity.

As previously mentioned, there is no cookie-cutter approach to counseling betrayed women, as every woman’s situation is different. However, there are many topics that Laaser addresses at various points in the counseling process: physical health, needing space/separation, making decisions, the roller coaster ride, the ampersand, managing anger, education about sexual addiction, living in the truth, rebuilding trust, boundaries and bottom lines, accountability partners, safe community, reframing distorted beliefs, knowing whether to stay or leave, forgiveness, and overriding old associations.

Asking about physical health from the beginning is highly beneficial. Issues to inquire about include sleep, nutrition, fatigue, stress, anxiety, and sexually-transmitted diseases (STDs), among others. Sometimes women feel shame and do not even want to think about the possibility of an STD or get tested, and the counselor should gently encourage her to consider it. The issue of space/separation should also be discussed, being sure to listen to what a woman feels she needs and desires instead of pushing one’s own opinion on her. Clients need to feel empowered to make decisions about their lives, as they typically have many that need to be made. Helping them slow down and listen to themselves, even simply having another person encourage them to trust themselves, can be very effective. The counselor should educate her that her healing journey will be more like a roller coaster rather than a smooth ride. This will help her not to have unrealistic expectations and to not lose hope in the midst of the ups and downs.

The ampersand is a technique in which the client learns the concept of “both/and” as opposed to “or,” a way of helping her to break away from black and white, extreme thinking. This concept can help her acknowledge the fullness of her reality and feel less confused, including seemingly opposite thoughts and feelings that can co-exist. Teaching the client to manage anger is fairly self-explanatory, as well as educating her about sexual addiction.

Laaser states that many women are the ones who found out about their husband’s infidelity rather than him initiating a confession; however, unless the truth is offered freely, there will always be doubt about whether they know the full truth and it will be difficult to feel like they are “living in the truth.” The counselor can help them feel validated for feeling this way, as well as educate her on what the husband needs to do in order to start rebuilding trust. Laaser provides a list of 7
behaviors that the husband must display in order to show he is working on becoming trustworthy. Offering daily updates on his sobriety is important. It is also important for women to continue learning to trust themselves and trust God in new ways, as previously mentioned. Many women are not used to trusting themselves and are not even aware that they have their own needs and desires, neither are they used to speaking up about them if they are aware. The counselor can encourage women to learn about their needs and to voice them, learning to set boundaries and bottom lines. Bottom lines are simply boundaries that are non-negotiable needs.

One of the boundaries that often needs to be set is the boundary of accountability, for often the woman says that she is her husband’s accountability partner. This is often problematic, as it creates a parent-child dynamic in the relationship. The husband needs to find other men to be his accountability partners. The woman also needs to find safe community, which can be found in group settings, particularly other women who have been through the same experience.

Finally, cognitive restructuring via reframing distorted beliefs, discussing whether a woman wants to stay or leave the marriage, examining the issues of forgiveness, and overriding old associations are other helpful strategies. Helping a woman create vision for moving forward with her life can be very beneficial. Although every woman is unique and every situation different, using the previously mentioned suggestions and simply being a safe person to come alongside her can be an invaluable part of her journey towards healing.

**Pedagogical Suggestions:**

- Have students research post-traumatic growth (PTG) and related counseling models, choosing an aspect of it to teach to the class through a presentation or a discussion board post. Then specifically discuss how this aspect could relate to counseling betrayed women.
- Laaser (2018) states that “the trauma of betrayal is like that of individuals struggling with post-traumatic symptoms from other life crises” (p. 579). Why would this be so? Discuss as a class or in groups.
- On page 582, Laaser gives 5 examples of the most unhelpful advice betrayed women reported receiving. Why would each of these examples be unhelpful or even damaging? Discuss as a class or in groups.
- Laaser discusses the importance of timing in relation to introducing a betrayed woman to “working on herself.” Based on information provided in the text, how would you be able to tell when the timing is right? How would you be able to tell when the timing is not right? Discuss as a class or in groups.
• Laaser discusses many characteristics of safe people. Are there any other characteristics you would add? Discuss as a class or in groups. Have everyone describe a safe person in their own words. Break into pairs and role-play to practice teaching the characteristics of safe people to a hypothetical client.

Chapter 27 Quiz (25 questions):

Fill-in-the-blank
1. According to Laaser, when wives were counseled, it was often from the __________________ model that suggested she was a co-addict and a codependent and had just as much to “work on” as the addict. (twelve-step)
2. A second model, which Laaser also deems to be ineffective, is the ______________ model, which validates the trauma of being betrayed but leaves the woman feeling like a powerless victim. (trauma)
3. ___________________________ is the positive personal change that is possible after experiencing a very traumatic event in one’s life. (post-traumatic growth, or PTG)
4. A violation of an expectation of emotional and/or physical exclusivity with one’s partner is called a _________________. (relationship betrayal)
5. Laaser uses Ecclesiastes 7:18, “It is good to grasp the one and not let go of the other. Whoever fears God will avoid all extremes,” to illustrate the concept of ________________, a way to help clients move away from black and white thinking. (the ampersand)
6. ______________ are simply needs or desires we have. (boundaries)
7. ________________ are boundaries that are absolutes. (bottom lines)
8. In Laaser’s research, betrayed women stated that the worst advice they were given was to __________________ immediately. (forgive and forget)

True/False
1. The trauma of betrayal is like that of individuals struggling with post-traumatic symptoms from other life crises. (T/F)
2. Laaser recommends letting the client know in the very first session that her husband’s betrayal was not her fault. (T/F)
3. Betrayed women should be introduced to “working on themselves” immediately in the counseling process. (T/F)
4. Many betrayed women expect their healing journey to be like a roller coaster ride, so it is important for counselors to let them know this is not the case and that their journey to healing will be smooth and quick. (T/F)

5. Most women know about infidelity because they found it. (T/F)

6. The husband’s offering daily information about his sobriety is extremely helpful in building trust. (T/F)

7. Expressing needs and desires is often a new experience for women. (T/F)

8. A woman should always be her husband’s main accountability partner. (T/F)

9. One should never advise a woman about staying or leaving. (T/F)

Multiple Choice

1. Laaser gives a description of safe people that can be given to clients. She states that a safe person has all of the following characteristics EXCEPT:
   a) Doesn’t give a lot of uninvited advice or judgement
   b) Doesn’t pry for more information than you want to share
   c) Won’t over-spiritualize your situation
   d) Won’t just try and “fix” you
   e) None of the above
   f) Only A and C

2. Which of the following is NOT one of the recommendations Laaser has for the first session with a betrayed woman?
   a) Asking her about safe people in her life
   b) Talking about her husband getting help if he hasn’t
   c) Letting her know her husband’s betrayal was not her fault
   d) Including some words of hope
   e) None of the above
   f) Only A and B

3. Laaser lists seven desires that are common to both men and women. Which of the following is NOT one of them?
   a) To be heard and understood
   b) To be affirmed
   c) To be chosen or desired
   d) To be included
   e) None of the above
   f) Only B through D

4. The best accountability partner for a man is:
   a) His wife
   b) Other men
   c) His parents
   d) His pet cat or dog
5. Which of the following is NOT one of the topics Laaser suggests to discuss with a betrayed woman during counseling?
   a) Boundaries and bottom lines
   b) Living in truth
   c) Managing anger
   **d) The importance of serving others**
   e) None of the above

6. Laaser recommends asking about all of the following physical health issues EXCEPT for:
   a) Sleep
   b) Nutrition
   c) Panic and anxiety
   d) Sexually transmitted disease (STD)
   **e) None of the above**
   f) Only C and D

7. According to Laaser, the second and third sessions with a betrayed woman should be
   a) Led by the client’s initiative
   b) Structured specifically for the purposes of assessment
   c) Led by the counselor’s initiative
   d) Mostly psychoeducational in nature
   e) None of the above

8. According to a research study cited by Laaser in the text, post-traumatic growth can:
   a) Create greater appreciation for life
   b) Create richer interpersonal relationships
   c) Increase personal strength
   d) Create new priorities
   **e) All of the above**
   f) Only A and B
Chapter 28
Couple Sexual Problems-Focused Strategies by Michael Sytsma, PhD

Key Terms: sexual problems/issues, Masters and Johnson behavioral model, self-of-the-therapist preparation, sexual attraction, disease, dysfunction, discomfort, aging, gender differences, pregnancy, childbirth, fatigue, stress, anatomy, physiology, communication, attributional errors, trauma, distress, the DEC-R model: dialogue, education, coaching, and referral, sexual dance, active listening, modeling, brakes and accelerators, models of sexual response, bibliotherapy, acceptance, grieving

Key Points:
- In this chapter, Sytsma discusses self-of-the-therapist preparation work, an overview of different types and sources of sexual problems, a general strategy, and the DEC-R, a model of therapy specifically designed for use with couple sexual problems.
- Sytsma posits that preparation of the self-of-the-therapist is more important for working with sexual issues than with any others.
- Sytsma recommends categorizing a sexual problem as either a disease, dysfunction, or discomfort.
- One common cause of sexual problems is a lack of knowledge about myriad topics: basic anatomy and physiology, effects of aging, pregnancy and childbirth, gender differences, and fatigue and stress.
- Other causes of sexual problems include poor sexual communication, attributional errors related to sexual issues, trauma, physiological issues, and divergent, distractive, or destructive sexual goals.
- Although many theories and models can be effective with sexual issues, Sytsma’s number one recommended strategy is the DEC-R, an acronym standing for Dialogue, Educate, Coach, and Refer.

Student Learning Objectives:
- To comprehend the necessary preparation and self-of-the-therapist work the counselor must engage in prior to counseling couples with sexual issues
- To be able to describe the common types and sources of sexual issues
To understand general strategy recommended by Sytsma for counseling couples with sexual issues, in addition to the various techniques involved with the DEC-R model

Chapter Summary:

Sexual problems are highly common, especially among couples who seek counseling, and therefore it is imperative that one become knowledgeable about the basics of working with sexual issues. In this chapter, Sytsma discusses self-of-the-therapist preparation work, an overview of different types and sources of sexual problems, general strategies, and the DEC-R, a model of therapy specifically designed for use with couple sexual problems. In general, the goal of such counseling is simply to help couples develop a healthy sexual life the way God created it to be.

Sytsma posits that preparation of the self-of-the-therapist is more important for working with sexual issues than with any others. Sexual attraction either towards a client or from a client will certainly happen at some point in this type of work, and the counselor should expect it in advance so as not to be surprised. Although counselors are often tempted to avoid or deny such attraction, it is important to realize that it is normal and to deal with it either through supervision, consultation, or personal therapy. Counselors should also prepare themselves to manage direct or graphic talk about sexual issues, stories of intense brokenness and shame, and stories that may even sound offensive such as those involving attraction towards underage individuals. If the counselor feels he cannot handle such issues, it is necessary to be humble and to make appropriate referrals.

Accurately identifying sexual issues is critical, as many couples often are not accurate in their own assessment of the problems; this requires the counselor to be knowledgeable about a wide range of sexual issues. The counselor should also learn how to gauge the severity and distress level associated with the identified problems during the assessment process. Sytsma recommends categorizing a sexual problem as either a disease, dysfunction, or discomfort. A disease by nature cannot be treated directly through counseling, but the distress can be, and counseling also provides a place to safely problem-solve. Dysfunctions include those mentioned in the DSM-5 or the ICD-10 such as erectile dysfunction or female orgasmic disorder. Although medical reasons could be the source of some of these dysfunctions, the relational aspects can certainly be treated through counseling. A discomfort may not meet criteria for a disease or dysfunction but may cause significant individual and relational distress. Examples of discomforts include disagreements about sexual positions, frequencies, and particular behaviors.
One common cause of sexual problems is a lack of knowledge about myriad topics: basic anatomy and physiology, effects of aging, pregnancy and childbirth, gender differences, and fatigue and stress. Clients may not be aware that the clitoris is the female equivalent of the male penis, that sexual difficulties are normal during the aging process, or that women take much longer to climax than men. Other causes include poor sexual communication; attributional errors related to sexual issues; trauma; physiological issues; and divergent, distractive, or destructive sexual goals. Regardless of the reason for the problem, it is crucial to help both partners take responsibility for it and to strive for a big-picture perspective rather than blaming each other and getting defensive.

A general strategy suggested by Sytsma is to attend to the symptoms or the distress rather than to the problem itself. This can be especially helpful if the problem has a medical cause, and clients can still achieve a successful outcome by finding ways to decrease their levels of distress even if the problem does not change. Although many theories and models can be effective with sexual issues, Sytsma’s number one recommended strategy is the DEC-R, an acronym standing for Dialogue, Educate, Coach, and Refer. This model was developed by Rosenau, Sytsma, and Taylor in 2002, and the DEC-R stages are not sequential, able to be used in any order at any point throughout therapy. That being said, it can be very helpful to use the stages sequentially at first to help lay a foundation.

Dialogue involves dialogue with the counselor and dialogue within the couple. The counselor must use dialogue to accurately identify the problem, severity, and distress level, as previously mentioned. Common marital assessments and standard intake forms can be helpful as well, as sometimes it may be easier for a client to bring up sexual issues through a form. It is critical that the counselor be at ease with asking direct questions about sexual issues, and he should specifically ask the couple to describe their sexual “dance” or usual routine of what happens when they decide to engage in sex. Couples rarely ever discuss this, which in and of itself can be a common source of sexual issues, and so discussing this with the couple in counseling can be highly beneficial. This is a great opportunity to help the clients move from dialogue with the counselor to dialogue with each other. The counselor should model good communication and active listening skills, another area in which couples are often lacking, and teach them to use these same skills when dialoging with each other. Other strategies for encouraging dialogue within the couple about sexual issues include asking them to read a book about sexual issues out loud together, make lists of their sexual brakes and accelerators, schedule “coffee time” (an agreed-upon time to review previous sexual experiences), and learn to identify sexual expectations and goals.

Education may need to occur at multiple times throughout therapy, and the counselor should be prepared to teach clients about myriad sexual topics. This
means that the counselor should be constantly reading the latest research on sexual issues and current treatments, as the field is always changing. Timing is also critical in the education process, and the counselor should always seek to learn what the client already knows before jumping in to share knowledge too quickly. Tone is also critical, as the counselor should strive to sound curious, explorative, proposing, and accepting. The most common topics the counselor ought to learn about in advance include basic sexual anatomy and physiology, effects of aging, gender differences, and different models of sexual response, among others.

Finally, the Coaching aspect focuses on helping couples actually engage in building a healthy sexual life and engage in homework assignments that can be helpful. Because homework can have negative connotations, it is important for the counselor to create a non-threatening setting and let the couple know that it is impossible to fail; even if they do not complete their homework, valuable information is still obtained by examining why this occurred. The counselor should also make sure the model of intervention he chooses is ethical and empirically supported for the client’s situation. Some coaching strategies recommended by Sytsma include bibliotherapy, helping the couple with acceptance and grieving, helping couples try any new techniques in session (ethically and within reason, such as a technique where the couple are assigned to caress each other’s hands for fifteen minutes), and to refer if necessary, as previously mentioned.

**Pedagogical Suggestions:**

- Ask students to reflect on their current perceived abilities to handle sexual flirting, direct sexual statements, reflexive sexual responses, educating on sexual topics, hearing stories of great brokenness, and hearing sexual stories that may be offensive. Also have them consider their current thoughts on working with couples in general in the future. Ask them to write a brief paper summarizing their conclusions, including how they might grow in these abilities or if they feel that they should plan to always refer instead.

- Ask students to each choose one of the areas of sexuality couples are commonly lacking in knowledge of, as listed in the text, and to conduct further independent research using other scholarly, peer-reviewed sources. Have students create a PowerPoint presentation, paper, or discussion board post on their chosen topic, and teach it to the rest of the class if time allows.

- Have students research common marital assessments such as the Dyadic Adjustment Scale or the Gottman Sound Relationship Scale that include specific questions about sexual functioning and become familiar with them.

- Have students research current educational resources and bibliotherapy that could be helpful for future clients who are struggling with sexual issues in
their marriage. Have them become familiar with these resources and compile a list, as well as develop a plan for how to continue staying up to date with current research and treatments for sexual issues.

Chapter 28 Quiz (25 questions):

Fill-in-the-blank
1. The first strategy one should always employ when working with sexual issues is _________________. (preparation)
2. The three broad categories Sytsma recommends for categorization of sexual issues are: ________________, (disease)
3. ________________, (dysfunction)
4. and _________________. (discomfort)
5. ________________ are beliefs regarding the causes of an event. (attributions)
6. One valuable strategy suggested by Sytsma for counseling couples with sexual issues is to attend to the ________________ rather than the problem itself. (distress)
7. The D in DEC-R stands for _________________. (dialogue)
8. The C in DEC-R stands for _________________. (coach)
9. The R in DEC-R stands for _________________. (refer)

True/False
1. Most couples who seek counseling will not present with sexual issues. (T/F)
2. Possibly more than any other type of counseling, working with sexual problems requires you to prepare yourself for the work. (T/F)
3. At some point in your career, sexual attraction toward clients and from clients will happen and is normal. (T/F)
4. While the problem might seem obvious, couples often wrongly identify it. (T/F)
5. Couples often are used to discussing each step of their lovemaking with each other. (T/F)
6. Childbirth is typically considered a positive event but is often the cause of sexual problems. (T/F)
7. All medications have the potential for side effects, but sexual problems are a very rare negative side effect. (T/F)
8. Couples develop a sexual routine early in their sexual relationship that tends to remain fairly habitual. (T/F)
Multiple Choice
1. When preparing oneself to work with sexual issues, one should prepare oneself to:
   a) Handle sexual flirting and direct sexual statements
   b) Hear great brokenness and shame
   c) Hear stories that may be offensive to you
   d) All of the above
   e) Only A and B
   f) None of the above
2. Examples of problems that would fall into the category of “discomfort” include all of the following EXCEPT:
   a) Disagreements over sexual positions
   b) **Erectile dysfunction**
   c) Differing opinions on sexual frequency
   d) Opposing views on sexual practices
   e) None of the above
   f) All of the above
3. Lack of knowledge about all of the following EXCEPT _______________ is a common reason behind sexual issues, according to the list provided by Sytsma.
   a) Basic anatomy and physiology
   b) Effects of aging
   c) **Sexual positions**
   d) Gender differences
   e) All of the above
4. Physiological issues that can effect sexual functioning include all of the following EXCEPT:
   a) Disability
   b) Aging
   c) Body size/shape
   d) Fatigue
   e) **None of the above**
   f) A through C
5. The E in DEC-R stands for:
   a) Engage
   b) **Educate**
   c) Enlist
   d) Ensure
   e) None of the above
6. Strategies mentioned by Sytsma that encourage dialogue among couples struggling with sexual issues include:
   a) Reading out loud together
   b) Listing brakes and accelerators
   c) Scheduling “coffee time”
   d) Identifying sexual expectations and goals
   e) All of the above
   f) Only A, B, and D

7. When providing clients with information on sexual issues, the counselor should:
   a) Inquire about what the clients already know first
   b) Propose information rather than definitely provide
   c) Use a curious, exploring tone
   d) Convey acceptance in his/her tone rather than rejection
   e) All of the above
   f) A through C only
   g) None of the above

8. When counseling couples with sexual issues, the most common topics the counselor should be prepared to teach on include all of the following EXCEPT:
   a) Gender differences
   b) The effects of aging
   c) Basic sexual anatomy
   d) Basic sexual physiology
   e) Only C and D
   f) None of the above
Midterm Exam (50 questions)

Fill-in-the-blank (16)

1. ______________ bias is the idea that we are all likely to see the world from our own framework and deny or attack any other model that challenges its ideas. (confirmation and selection)

2. The ______________ technique involves asking the client to assume a cognition is true and to then ask a series of “if…then” questions to ultimately uncover an underlying core belief or schema. (downward arrow/vertical arrow)

3. In the __________ technique, the therapist asks the client if he or she would use the same negative, perfectionistic, black-and-white patterns of thinking to relate to a dear friend, e.g. “What would you say to a friend who is in the exact same situation as you?” (double-standard technique)

4. ______________ is defined as the extent to which one understands his or her emotional experiences. (emotional clarity)

5. The ______________ technique involves learning new behavior by considering the behavior a reality and anticipating it as expected. (act as if)

6. ______________ is a technique used either to link aversive consequences associated with the target or to perform target behaviors through imagining them occurring. (imaginal rehearsal)

7. In the A-B-C assessment technique, the A stands for ______________. (antecedents)

8. ______________ is a term carried over from the first wave of behavior therapy, denoting two contradictory or incompatible physiological responses. (reciprocal inhibition)

9. “If you don’t study for your upcoming math test, we will have a better idea of what would happen if you actually fail” is an example of ______________, a provocation technique. (paradox)

10. There are two empirically-supported models of forgiveness, one developed by ______________ (Enright)

11. and one developed by ______________. (Worthington)

12. The psychiatrist Karl Lehman developed the Christian inner healing prayer strategy known as ______________. (the Immanuel approach)

13. Cooley referred to our individual identity as the reflected or ______________: a self that develops through our perception of how others respond to our behavior. (looking-glass self)

14. ______________ coping involves changing how one thinks about a problem or stressor in order to reduce anxiety. (appraisal-focused)
15. _____________ assists in minimizing the common “thinking errors” that occur when we cope by identifying and confronting these distortions. (cognitive restructuring)

16. Attachment theory is a _____________ theory, which is a theory that helps us make sense of other theories. (meta)

True/False (18)

1. The therapeutic relationship itself is not considered a SIT. (T/F)
2. The measuring stick for counseling efficacy is client outcome, which is defined ultimately by the counselor. (T/F)
3. A prerequisite of an effective intervention or technique is timing. (T/F)
4. One challenge to EBTs is that the counseling field measures outcomes using secondary data rather than primary data. (T/F)
5. Emotion regulation can best be defined as “all of the processes, intrinsic and extrinsic, through which individuals manage their emotions to accomplish their goals.” (T/F)
6. Whereas chaining is appropriate for learning simple behaviors, complex behaviors require shaping. (T/F)
7. Sand tray therapy is typically considered a play therapy activity for children only and is not effective with adults. (T/F)
8. Younger generations seem to find meaning in art forms more than in words. (T/F)
9. The destruction-creation polarity is listed as one of Levinson’s four polarities affecting a midlife crisis. (T/F)
10. One limitation to cognitive restructuring is that acute emotional discomfort can interfere with activating the higher order thinking that it requires. (T/F)
11. In the SECURE model, the exploration system and the attachment system can both be operating at the same time. (T/F)
12. For those with an avoidant attachment style, the attachment system is underactivated and the exploration system is overactivated. (T/F)
13. Adolescent clients do not typically present for counseling on their own volition. (T/F)
14. Clinicians do not need to obtain written parental consent to provide treatment to a minor client. (T/F)
15. The counselor should always gain personal experience utilizing each artistic medium prior to incorporating the medium into therapeutic practice. (T/F)
16. Individuals who struggle with borderline personality disorder and post-traumatic stress disorder (PTSD) are excellent candidates for silence and solitude. (T/F)
17. Behavioral deficits describe behaviors or skills that are underdeveloped in terms of frequency, duration, intensity, or effectiveness. (T/F)
18. A behavioral hierarchy involves constructing a staircase outlining the situations that can lead to skill development, and ranking the items to move from least complex to greater complexity. (T/F)

Multiple Choice (16)
1. The individual said to have initiated the EBT movement was:
   a) Eysenck  
   b) **Freud**  
   c) Nietzsche  
   d) Sackett
2. Which of the following are examples of cognitions, according to the text?
   a) Attention  
   b) Beliefs  
   c) Expectations  
   d) Categorization of stimuli  
   e) **All of the above**  
   f) Only A and D
3. The individual responsible for the “still face experiment” was:
   a) **Tronick**  
   b) Plutchik  
   c) Panksepp  
   d) Lopez  
   e) None of the above
4. Our neurobiology is designed to prioritize stimuli with:
   a) High potential for novelty  
   b) Greater familiarity  
   c) High primitiveness  
   d) **A and C**  
   e) A and B
5. Which of the following are listed as prominent features of alexithymia?
   a) The reduced capacity for analyzing emotions  
   b) Difficulty verbalizing emotional experiences  
   c) Emotionalizing, or reduced ability to determine origins of emotions  
   d) Diminished fantasy life  
   e) **All of the above**  
   f) Only A and C
6. Perhaps the most foundational exercise that one can participate in to regulate one’s emotional state is ____________.
a) Progressive muscle relaxation  

b) **Diaphragmatic breathing**  
c) Guided imagery/visualization  
d) Autogenic phrases  
e) None of the above  

7. Becoming aware of fluctuating inner states so that a more deliberate course of action can be taken is known as:  
a) Acceptance and Commitment Therapy (ACT)  

b) **Mindfulness**  
c) Willingness  
d) The A-B-C technique  
e) Magic  

8. __________ is the creator of ordeal therapy.  
a) Haley  
b) Thomas  
c) Firestone  
d) Murray  
e) None of the above  

9. According to the text, a biblical view of self involves:  
a) People have a body, soul, and spirit.  
b) Humans reflect the image of God.  
c) Humans have the unique ability to communicate with God.  
d) Humans are tasked with responsibility for God’s creation.  
e) **All of the above**  
f) Only A through C  
g) None of the above  

10. The three categories of child self-development identified by Harter include all of the following except:  
a) Self-continuity  
b) Self-agency  
c) **Self-congruency**  
d) Self-awareness  
e) None of the above  

11. Elements of sand tray therapy must include all of the following except:  
a) A tray of sand  
b) Water  
c) A collection of miniatures  
d) **Paper and pencils**  
e) None of the above
12. Individual psychology identifies which of the following as one of the four goals of misbehavior?
   a) Inadequacy
   b) Attention
   c) Revenge
   d) Power
   **e) All of the above**
   f) None of the above

13. The acronym ESSENCE, meaning “emotional spark, social engagement, novelty seeking, and creative expression” was coined by ______________ to describe the key features of adolescence.
   a) Siegel
   b) Thacker
   c) Erikson
   d) Yarhouse & Hill
   e) None of the above

14. The main structure in the brain going through major changes during adolescence, according to the text, is:
   a) Prefrontal cortex
   b) Amygdala
   c) Hypothalamus
   d) Temporal lobes
   e) None of the above

15. ______________ help(s) clients differentiate past toxic relationships from the present therapeutic relationship through asking the client a series of questions.
   a) Significant other history
   b) Interpersonal situation analysis
   c) **Interpersonal discrimination exercises**
   d) Transference hypothesis
   e) None of the above

16. The following statement is an example of ______________ attachment:
   *I’m not worthy of love, and I desperately need others to take care of me, but I must be in great need in order for her to respond to my emotions.*
   a) Secure
   b) Avoidant
   **c) Preoccupied**
   d) Fearful-avoidant
   e) None of the above
Final Exam (50 questions)

Fill-in-the-blank (16)

1. ________________ is the ability of the human brain to grow stronger through use and stimulation. (neuroplasticity)
2. When those with personality disorders continue to repeat the same mistakes over and over without learning from them, this is known as ________________. (emotional and interpersonal dyslexia, EID)
3. _______________ are tasks that the counselor asks a family to do in session or to accomplish at home for the purpose of building a healthier pattern of behavior between family members. (directives)
4. Aponte’s model, the _______________ model, involves a focus on family of origin influence on counselors’ practices. (person-of-the-therapist)
5. DiBlasio cites _______________’s work to describe counseling sessions as similar to dramatic productions. (Freytag)
6. The “C” in Baker’s ABC guide stands for _______________ theological understandings. (clarify)
7. ________________ is a behavioral intention to refrain from seeking revenge and to treat an offender as a valued and valuable person. (decisional forgiveness)
8. ________________ is defined as restoring trust in a relationship, which requires mutually trustworthy behavior. (reconciliation)
9. Children feel ________________ when what they need to feel human is withheld. (shame)
10. Parental _______________ is what is often missing in the history of shame-prone clients. (attunement)
11. The ________________ technique involves writing down one’s shame-infused beliefs on pieces of paper and putting them in a box, followed by reflection/journaling about the beliefs while learning to tolerate feelings of shame. (shame box)
12. Gingrich refers to the first phase of CT treatment as _______________. (safety and symptom stabilization)
13. The four main reasons described in the literature as to why people engage in self-harm are: ________________, (physical grounding)
14. ________________, (control)
15. ________________, (the silent scream)
16. and ________________. (self-punishment)
True/False (18)
1. Those with personality disorders have been shown to have brain structures that are smaller, with grey and white matter being less in volume. (T/F)
2. One of the classic principles of family therapy is realigning family hierarchy so that parents are in charge of their children. (T/F)
3. A by-product of the parent giving nurturance is an elevation of hierarchy. (T/F)
4. The family of origin session is open to spouses and other family friends, if desired. (T/F)
5. Those with a volatile conflict style are clear about their opinions and have no problem arguing and persuading. (T/F)
6. A validating conflict style is superior to other styles in terms of couple satisfaction and stability. (T/F)
7. In cases of domestic violence, reconciliation is extremely difficult, often impossible. (T/F)
8. In the majority of cases, women who are or have been victims of domestic violence want to be able to tell their stories. (T/F)
9. During the A phase of a psychoeducational REACH group, the leader asks group members to reflect on a time when they offended someone who forgave them. (T/F)
10. The first phase of CT treatment usually takes not months but years. (T/F)
11. Even those with CT who do not have DID often experience some degree of personality fragmentation. (T/F)
12. Most prominent among all definitions of self-injury is the idea that the self-harm cannot be a suicide attempt. (T/F)
13. The greatest number of reported cases of self-harm consistently occurs during childhood. (T/F)
14. In the text, bereavement, grief, and mourning are considered to be interchangeable terms for the same concept. (T/F)
15. In sex addiction treatment, ask clients to tell you about their fantasies, but let them know that details should always be avoided. (T/F)
16. According to research, very few wives have responded to disclosure of infidelity with post-traumatic stress disorder (PTSD) symptoms. (T/F)
17. The normal healing process after infidelity is about 1 to 2 years. (T/F)
18. Most couples who seek counseling will not present with sexual issues. (T/F)

Multiple Choice (16)
1. When humans are emotionally hurt or under emotional threat, the ____________ is activated much like it is when under physical threat.
   a) Amygdala
b) Hippocampus  
c) Temporal lobe  
d) Prefrontal cortex  
e) None of the above  
2. Strategic family therapy was created by:   
a) Haley and Madanes  
b) Madanes and Satir  
c) Haley and Weakland  
d) Haley and Satir  
e) None of the above  
3. Which of the following is NOT one of the steps involved in the time-out procedure?   
a) Set a private pretend practice time for each child.  
b) When a child commits a violation, calmly request that the child go to the time-out chair or mat.  
c) After the time-out, discuss the violation and why the child thinks the violation was wrong.  
d) If the child refuses to go to the chair or mat, sit on the chair or mat with the child and talk to him throughout the time-out.  
e) None of the above  
4. The goal of ________________ is to reestablish connection between family members by creating new emotional and interactive experiences.   
a) Emotion-focused family therapy  
b) The Gottman Method  
c) The Maudsley approach  
d) Bowenian family therapy  
e) None of the above  
5. According to the text, Christian women in domestic violence situations may believe that forgiveness includes:  
a) Forgetting or excusing the offense  
b) Engaging in mediation  
c) Seeking reconciliation  
d) All of the above  
e) None of the above  
6. Settings in which REACH can be used include all of the following EXCEPT:   
a) Do-it-yourself workbooks  
b) Psychoeducational groups  
c) Couples counseling  
d) Family counseling
7. In a group setting of REACH, “the leader reads one of six scriptural passages about forgiveness, then whips around the group, and each member reacts with a word.” This part of the group is called:
   a) Creating a working definition
   b) Lectio divina
   c) Icebreaker
   d) Inviting decisional forgiveness
   e) None of the above

8. When working with shame, the first therapeutic task (bonding with the client) involves all of the following techniques EXCEPT:
   a) Hyperfocus on being nonshaming
   b) Practice attunement
   c) Check in
   d) Avoid attempting to “talk clients out of it”
   e) None of the above
   f) Only A and C

9. _____________ is the process by which people make sense of the world by imaging how other peoples’ state of mind can influence behavior.
   a) Mindfulness
   b) Mentalization
   c) Radical acceptance
   d) Mirroring
   e) None of the above

10. Which of the following is listed as a strategy for helping the counselor be and remain a safe person during phase one of CT treatment?
   a) Remember that every client is unique.
   b) Warn of impending change.
   c) Know your limitations.
   d) Keep appropriate boundaries.
   e) All of the above
   f) Only C and D

11. Things you should warn your CT clients about include:
   a) Missing a session for a conference
   b) Putting a new picture on your wall
   c) Changing appointment times
   d) Any major issues going on in your life
   e) All of the above
   f) A through C only
12. Cutting could be viewed as all of the following but is MOST COMMONLY:
   a) Suicide attempts
   b) Evidence of borderline personality disorder
   c) **Its own phenomenon not associated with suicidality, BPD, or OCD**
   d) Evidence of obsessive compulsive disorder (OCD)
   e) None of the above

13. When the griever becomes more functional and seeks new and realistic solutions to life and problems posed, this is known as which stage of grief?
   a) Accepting and hope stage
   b) **Reconstruction stage**
   c) The upward turn
   d) Anger and bargaining stage
   e) None of the above

14. All of the following are stages in the sexual addiction cycle EXCEPT:
   a) Preoccupation or fantasy
   b) Rituals
   c) Acting out
   d) Despair
   e) **None of the above**
   f) Only C and D

15. The best accountability partner for a man is:
   a) His wife
   b) **Other men**
   c) His parents
   d) His pet cat or dog
   e) None of the above

16. The E in DEC-R stands for:
   a) Engage
   b) **Educate**
   c) Enlist
   d) Ensure
   e) None of the above
Sample Syllabi

Counseling Techniques
Syllabus (Mon/Wed/Fri)

I. Course description
This course will provide students with both theoretical and practical information on a wide variety of counseling strategies, interventions, and techniques (SITs) divided into three categories: theory-based strategies, population-based strategies, and clinical issue-based strategies.

II. Intended learning outcomes:
At the end of this course, students will be expected to:
1. Comprehend the psychology and theology behind a wide variety of effective counseling techniques for a wide variety of issues and populations as mentioned in the text;
2. Be able to describe the various nuances, research findings, and related issues surrounding the strategies, interventions, and techniques (SITs) discussed in the text;
3. Understand the myriad strategies, interventions, and techniques (SITs) presented in the text for each stated population and/or issue.

III. Outline of the weekly course schedule:

Week 1
- Mon – Class intro/syllabus/assignment overview
- Wed – Laying the Groundwork
  o Read Ch. 1 (pp. 13-27)
  o Quiz #1
- Fri – Evidence-Based Counseling
  o Read Ch. 2 (pp. 31-43)
  o Quiz #2

Week 2
- Mon – Cognitive-Based Strategies
  o Read Ch. 3 (pp. 44-68)
- Wed – Cognitive-Based Strategies (cont’d)
Quiz #3
• Fri – Emotion-Oriented Strategies
  o Read Ch. 4 (pp. 69-85)
  o Quiz #4

Week 3
• Mon – Emotional Dysregulation Strategies
  o Read Ch. 5 (pp. 86-109)
  o Quiz #5
• Wed – Behavioral Strategies
  o Read Ch. 6 (pp. 110-133)
• Fri – Behavioral Strategies (cont’d)
  o Quiz #6

Week 4
• Mon – Behavioral Dysfunction Strategies
  o Read Ch. 7 (pp. 134-152)
  o Quiz #7
• Wed – Experiential Strategies
  o Read Ch. 8 (pp. 153-176)
• Fri – Experiential Strategies (cont’d)
  o Quiz #8

Week 5
• Mon – Spiritual Strategies
  o Read Ch. 9 (pp. 177-196)
• Wed – Spiritual Strategies (cont’d)
  o Quiz #9
• Fri – Christian Formation of the Self Strategies
  o Read Ch. 10 (pp. 197-220)
  o Quiz #10

Week 6
• Mon – Coping Skills Strategies
  o Read Ch. 11 (pp. 221-240)
• Wed – Coping Skills Strategies (cont’d)
  o Quiz #11
• Fri – Attachment-Oriented Strategies
  o Read Ch. 12 (pp. 241-265)
o Quiz #12

Week 7
• Mon – Child-Focused Strategies
  o Read Ch. 13 (pp. 269-289)
  o Quiz #13
• Wed – Adolescent-Focused Strategies
  o Read Ch. 14 (pp. 290-309)
  o Quiz #14
• Fri – Activity/Play-Therapy Day

Week 8
• Mon – Review for the mid-term exam
• Wed – Review for the mid-term exam (cont’d)
  o Mid-term exam
• Fri – Couple-Focused Strategies
  o Read Ch. 15 (pp. 310-331)
  o Quiz #15

Week 9
• Mon – Family-Focused Strategies
  o Read Ch. 16 (pp. 332-350)
  o Quiz #16
• Wed – Family of Origin-Focused Strategies
  o Read Ch. 17 (pp. 353-373)
  o Quiz #17
• Fri – Family Therapy Practice Day

Week 10
• Mon – Family Conflict-Focused Strategies
  o Read Ch. 18 (pp. 374-399)
• Wed – Family Conflict-Focused Strategies (cont’d)
  o Quiz #18
• Fri – Domestic Violence-Focused Strategies
  o Read Ch. 19 (pp. 400-416)
  o Quiz #19

Week 11
• Mon – Forgiveness-Focused Strategies: The REACH Forgiveness Model
- Read Ch. 20 (pp. 417-437)
- Quiz #20
- Wed – Shame-Focused Strategies
  - Read Ch. 21 (pp. 438-465)
- Fri – Shame-Focused Strategies (cont’d)
  - Quiz #21

**Week 12**
- Mon – Trauma-Focused Strategies
  - Read Ch. 22 (pp. 466-487)
  - Quiz #22
- Wed – Nonsuicidal Self-Injury-Focused Strategies
  - Read Ch. 23 (pp. 487-509)
- Fri – Nonsuicidal Self-Injury-Focused Strategies (cont’d)
  - Quiz #23

**Week 13**
- Mon – Loss-Focused Strategies
  - Read Ch. 24 (pp. 510-530)
  - Quiz #24
- Wed – Sexual Addiction-Focused Strategies
  - Read Ch. 25 (pp. 531-555)
- Fri – Sexual Addiction-Focused Strategies (cont’d)
  - Quiz #25

**Week 14**
- Mon – Infidelity-Focused Strategies
  - Read Ch. 26 (pp. 556-576)
- Wed – Infidelity-Focused Strategies (cont’d)
  - Quiz #26
- Fri – Betrayed Spouse-Focused Strategies
  - Read Ch. 27 (pp. 577-597)
  - Quiz #27

**Week 15**
- Mon – Couple Sexual Problems-Focused Strategies
  - Read Ch. 28 (pp. 598-620)
- Wed – Couple Sexual Problems-Focused Strategies (cont’d)
  - Quiz #28
• Fri – Presentations

  Week 16
• Mon – Presentations
• Wed – Presentations/Review for final exam
• Fri – Review for final exam
  o Final exam
Counseling Techniques
Syllabus (Tues/Thurs)

I. Course description
This course will provide students with both theoretical and practical information on a wide variety of counseling strategies, interventions, and techniques (SITs) divided into three categories: theory-based strategies, population-based strategies, and clinical issue-based strategies.

II. Intended learning outcomes:
At the end of this course, students will be expected to:
1. Comprehend the psychology and theology behind a wide variety of effective counseling techniques for a wide variety of issues and populations as mentioned in the text;
2. Be able to describe the various nuances, research findings, and related issues surrounding the strategies, interventions, and techniques (SITs) discussed in the text;
3. Understand the myriad strategies, interventions, and techniques (SITs) presented in the text for each stated population and/or issue.

III. Outline of the weekly course schedule:

Week 1
• Tues – Laying the Groundwork
  o Read Ch. 1 (pp. 13-27)
  o Quiz #1
• Thurs – Evidence-Based Counseling
  o Read Ch. 2 (pp. 31-43)
  o Quiz #2

Week 2
• Tues – Cognitive-Based Strategies
  o Read Ch. 3 (pp. 44-68)
  o Quiz #3
• Thurs – Emotion-Oriented Strategies
  o Read Ch. 4 (pp. 69-85)
  o Quiz #4

Week 3
• Tues – Emotional Dysregulation Strategies  
  o Read Ch. 5 (pp. 86-109)  
  o Quiz #5  
• Thurs – Behavioral Strategies  
  o Read Ch. 6 (pp. 110-133)  
  o Quiz #6  

Week 4  
• Tues – Behavioral Dysfunction Strategies  
  o Read Ch. 7 (pp. 134-152)  
  o Quiz #7  
• Thurs – Experiential Strategies  
  o Read Ch. 8 (pp. 153-176)  
  o Quiz #8  

Week 5  
• Tues – Spiritual Strategies  
  o Read Ch. 9 (pp. 177-196)  
  o Quiz #9  
• Thurs – Christian Formation of the Self Strategies  
  o Read Ch. 10 (pp. 197-220)  
  o Quiz #10  

Week 6  
• Tues – Coping Skills Strategies  
  o Read Ch. 11 (pp. 221-240)  
  o Quiz #11  
• Thurs – Attachment-Oriented Strategies  
  o Read Ch. 12 (pp. 241-265)  
  o Quiz #12  

Week 7  
• Tues – Child-Focused Strategies  
  o Read Ch. 13 (pp. 269-289)  
  o Quiz #13  
• Thurs – Adolescent-Focused Strategies  
  o Read Ch. 14 (pp. 290-309)  
  o Quiz #14
Week 8
• Tues – Review for the mid-term exam
  o Mid-term exam
• Thurs – Couple-Focused Strategies
  o Read Ch. 15 (pp. 310-331)
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• Tues – Family-Focused Strategies
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- Tues – Couple Sexual Problems-Focused Strategies
  - Read Ch. 28 (pp. 598-620)

- Thurs – Presentations
  - Quiz #28

Week 16

- Tues – Presentations/review for final exam
- Thurs – Review for final exam
  - Final exam