Fall 2018

CE 653 Syllabus: Theory & Practice of Sexual, Substance Abuse

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Winona State University Counselor Education Department CE 653: Theory & Practice of Sexual, Substance Abuse and Crisis Counseling Semester Hours: 4	
Course Location	Gildemeister Hall 325, Winona Campus
Instructor	Mary Fawcett, Ph.D., LPC, NCE; Mitch Moore, Ph.D. LADC-S
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Program Website	https://www.winona.edu/counseloreducation/
Instructor Office Location	Fawcett: 132 Gildemeister Hall, Winona, MN 55987 Moore: 400 South Broadway, Suite 300, Rochester MN, 55904
Instructor Office Hours:	Fawcett: Mondays and Thursdays, 12-4pm and other times by appointment Moore: Tuesday & Thursday (Rochester), 12-4 PM, or by appointment

I. COURSE DESCRIPTION

This 4-credit course will provide theoretical frameworks and practical skill building in the counseling of student and clients with sexual concerns, substance abuse and addiction issues, and crisis interventions. This course facilitates knowledge, awareness and skill development as it relates to student growth and development in preparation to work with client concerns in these sensitive topic areas. Students practice application of counseling theories in a laboratory setting with simulated situations. A strong emphasis is placed on the ethical standards of the counseling profession and on multicultural issues.

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II. COURSE PREREQUISITES

Prerequisites: CE 658 - Microskills & CE 660 - Counseling Theory and Practice. Grade only. Offered annually.

III. COURSE OBJECTIVES

Upon completion of this course the student will be able to:

1. Increase knowledge of sexual development and sexuality across the life span.
   *This learning outcome will be assessed by case studies.
2. Increase comfort with discussing sexuality and sexual concerns of clients.
   *This learning outcome will be assessed by taking a pre/post self-assessment of student comfort level and shared with the instructor.
3. Increase knowledge of sexual dysfunctions and current treatment approaches.

*This learning outcome will be assessed by case studies.

4. Increase knowledge of treatment approaches for sexual difficulties from different theoretical orientations.
   *This learning outcome will be assessed by graded role-plays on each topic area
5. Develop counseling skills and techniques for working with a variety of clients including persons with differing sexual values, needs, and backgrounds regarding sexuality concerns.
   *This learning outcome will be assessed by graded role-plays on each topic area.
6. Develop ethical behaviors regarding sexuality counseling including the recognition of personal limitations in this context.
   *This learning outcome will be assessed by case studies.
7. Advance knowledge in the field of human sexuality through critical evaluation of current research/presentation.
   *This learning outcome will be assessed by the assignment of literature review/presentation.
8. Identify and differentiate addictive substance and behaviors, as well as diagnostic symptoms and criteria of substance abuse and dependence.
   *This learning outcome will be assessed with case studies.
9. Recognize and become familiar with the principles of addiction counseling and research-based treatments used in addiction counseling.
   *This learning outcome will be assessed with case studies and a literature review/presentation.
10. Develop basic skills for working with clients with addictions.
    *This learning outcome will be assessed by graded role-plays on each topic area.
11. Recognize the major theoretical frameworks and current treatment modalities of addictions counseling.
    *This learning outcome will be assessed by graded role-plays on each topic area.
12. Recognize the nature and typical anatomy of a personal crisis.
    *This learning outcome will be assessed by case studies.
13. Identify and increase knowledge about crisis-intervention strategies and current practices, including referral for post-crisis counseling.
    *This learning outcome will be assessed by graded role-plays on each topic area.
14. Develop basic skills for working with clients in crisis and management of external factors involving family and friends of clients in crisis.
    *This learning outcome will be assessed by graded role-plays on each topic area.
15. Demonstrate multicultural competent practices when working with individuals from diverse backgrounds when managing sexual, addictive or crisis issues.
    *This learning outcome will be assessed by graded role-plays on each

topic area, and via a literature review/presentation.

IV. COURSE REQUIRED TEXTS, RESEARCH BASE & TECHNOLOGY

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th Ed). Washington, DC: American Psychiatric Publishing.

Hyde, J., & DeLamater, J. (2013). *Understanding human sexuality, 12th Ed.* ISBN-13: 9780078035395

Jackson-Cherry, L. R. & Erford, B. T. (2014). *Crisis assessment, intervention, and prevention, 2nd Ed.* ISBN-13: 9780132946964

Fisher, G. L. & Harrison, T. C. (2018). *Substance Abuse: Information for School Counselors, Social Workers, and Counselors, 6th Ed.* Boston: Pearson. ISBN-13: 9780134387451

Orenstein, P. (2016). Girls and Sex. New York: HarperCollins Publishers.

Additional materials and resources posted on the related course D2L page.

V. COURSE CONTENT AREAS

This course meets the Council for the identified Accreditation of Counseling and Related Educational Programs (CACREP, 2009) core content standards. Standards for the **Clinical Mental Health Counseling,** and/or **School Counseling** content areas are outlined below as well (if applicable). The evaluation methods linked to specific standards for CE ___are included.

- Add rows as needed
- Be sure to use headings to clearly identify and differentiate between the (a) 8 core content areas, and (b) either CMHC or School Standards
- Only include standards you are assessing, not merely mentioning in a lecture or class discussion. If it is a skills & practices standard, you need a skill-based assessment. If you do not use a standardized assessment (i.e., the CCS), provide clear examples /rubrics of how you assess the skills & practices standard.

2009 CACREP STANDARDS CORE	Counseling Demonstration Tapes	**Case Studies**	Topic Presentation
1. PROFESSIONAL ORIENTATION AND ETHICAL PRACTICE			
1c. Counselors' roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster or other trauma-causing event.	X	X	X
3. HUMAN GROWTH AND DEVELOPMENT			
3c. Effects of crises, disasters, and other trauma-causing events on persons of all ages.		X	X

2009 CACREP STANDARDS CLINICAL MENTAL HEALTH COUNSELING			
FOUNDATION **A. Knowledge**	Counseling Demonstration Tapes	**Case Studies**	Topic Presentation
A2. Understands ethical and legal considerations specifically related to the practice of clinical mental health counseling.	X		
A3. Understands the roles and functions of clinical mental health counselors in various practice settings and the importance of relationships between counselors and other professionals, including interdisciplinary treatment teams.		X	X
A4. Knows the professional organizations, preparation standards, and credentials relevant to the practice of clinical mental health counseling.		X	
A5. Understands a variety of models and theories related to clinical mental health counseling, including the methods, models, and principles of clinical supervision.	X		
A6. Recognizes the potential for substance use disorders to mimic and coexist with a variety of medical and psychological disorders.	X	X	
A7. Is aware of professional issues that affect clinical mental health counselors (e.g., core provider status, expert witness status, access to and practice privileges within managed care systems).		X	
A2. Understands ethical and legal considerations specifically related to the practice of clinical mental health counseling.	X		
A9. Understands the impact of crises, disasters, and other trauma-causing events on people.	X	X	
A10. Understands the operation of an emergency management system within clinical mental health agencies and in the community.		X	
B. Skills and Practices			
B1. Demonstrates the ability to apply and adhere to ethical and legal standards in clinical mental health counseling.	X	X	X

COUNSELING, PREVENTION, AND INTERVENTION **C. Knowledge**			
C1. Describes the principles of mental health, including prevention, intervention, consultation, education, and advocacy, as well as the operation of programs and networks that promote mental health in a multicultural society.			X
C2. Knows the etiology, the diagnostic process and nomenclature, treatment, referral, and prevention of mental and emotional disorders.		X	
C3. Knows the models, methods, and principles of program development and service delivery (e.g., support groups, peer facilitation training, parent education, self-help).		X	
C4. Knows the disease concept and etiology of addiction and co-occurring disorders.	X	X	
C5. Understands the range of mental health service delivery—such as inpatient, outpatient, partial treatment and aftercare—and the clinical mental health counseling services network.		X	
C6. Understands the principles of crisis intervention for people during crises, disasters, and other trauma-causing events.		X	
C7. Knows the principles, models, and documentation formats of biopsychosocial case conceptualization and treatment planning.	X		
C8. Recognizes the importance of family, social networks, and community systems in the treatment of mental and emotional disorders.	X		
C9. Understands professional issues relevant to the practice of clinical mental health counseling.	X	X	X
D. Skills and Practices			
D2. Applies multicultural competencies to clinical mental health counseling involving case conceptualization, diagnosis, treatment, referral, and prevention of mental and emotional disorders.	X	X	X
D3. Promotes optimal human development, wellness, and mental health through prevention, education, and advocacy activities.		X	X

D5. Demonstrates appropriate use of culturally responsive individual, couple, family, group, and systems modalities for initiating, maintaining, and terminating counseling.	X		
D6. Demonstrates the ability to use procedures for assessing and managing suicide risk.	X		
D8. Provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders.	X		
D9. Demonstrates the ability to recognize his or her own limitations as a clinical mental health counselor and to seek supervision or refer clients when appropriate.	X		
DIVERSITY AND ADVOCACY **E. Knowledge**			
E1. Understands how living in a multicultural society affects clients who are seeking clinical mental health counseling services.	X		
E2. Understands the effects of racism, discrimination, sexism, power, privilege, and oppression on one's own life and career and those of the client.	X	X	
E3. Understands current literature that outlines theories, approaches, strategies, and techniques shown to be effective when working with specific populations of clients with mental and emotional disorders.		X	X
E5. Understands the implications of concepts such as internalized oppression and institutional racism, as well as the historical and current political climate regarding immigration, poverty, and welfare.		X	X
F. Skills and Practices			
F1. Maintains information regarding community resources to make appropriate referrals.		X	X
F2. Advocates for policies, programs, and services that are equitable and responsive to the unique needs of clients.	X		
F3. Demonstrates the ability to modify counseling systems, theories, techniques, and interventions to make them culturally appropriate for diverse populations.	X		
ASSESSMENT **G. Knowledge**			
G1. Knows the principles and models of assessment, case conceptualization, theories of human development, and concepts of normalcy and psychopathology leading to diagnoses and appropriate counseling treatment plans.	X		

G2. Understands various models and approaches to clinical evaluation and their appropriate uses, including diagnostic interviews, mental status examinations, symptom inventories, and psychoeducational and personality assessments.	X		
G3. Understands basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications so that appropriate referrals can be made for medication evaluations and so that the side effects of such medications can be identified.		X	
G4. Identifies standard screening and assessment instruments for substance use disorders and process addictions.	X		
H. Skills and Practices			
H1. Selects appropriate comprehensive assessment interventions to assist in diagnosis and treatment planning, with an awareness of cultural bias in the implementation and interpretation of assessment protocols.	X	X	
H3. Screens for addiction, aggression, and danger to self and/or others, as well as co-occurring mental disorders.		X	
H4. Applies the assessment of a client's stage of dependence, change, or recovery to determine the appropriate treatment modality and placement criteria within the continuum of care.		X	
RESEARCH AND EVALUATION **I. Knowledge**			
I3. Knows evidence-based treatments and basic strategies for evaluating counseling outcomes in clinical mental health counseling.	X		
DIAGNOSIS **K. Knowledge**			
K1. Knows the principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).		X	X
K2. Understands the established diagnostic criteria for mental and emotional disorders, and describes treatment modalities and placement criteria within the continuum of care.		X	X

K3. Knows the impact of co-occurring substance use disorders on medical and psychological disorders.	X		
K4. Understands the relevance and potential biases of commonly used diagnostic tools with multicultural populations.	X	X	X
K5. Understands appropriate use of diagnosis during a crisis, disaster, or other trauma-causing event.		X	X
L. Skills and Practices			
L1. Demonstrates appropriate use of diagnostic tools, including the current edition of the DSM, to describe the symptoms and clinical presentation of clients with mental and emotional impairments.	X	X	X
L2. Is able to conceptualize an accurate multi-axial diagnosis of disorders presented by a client and discuss the differential diagnosis with collaborating professionals.	X	X	X
L3. Differentiates between diagnosis and developmentally appropriate reactions during crises, disasters, and other trauma-causing events.	X	X	X

VI. METHODS OF INSTRUCTION

The instructor will employ a variety of instructional methods to facilitate student learning including:

Basic instructional plan and teaching methods utilized include the following:

- Lecture/ discussion
- Videotapes and modeling
- Videotaped role-plays with peer feedback
- Case studies and responses to manual exercises

VII. COURSE EVALUATION METHODS

Course Obj.	Assignment	CACREP Standards Assessed Code: Core/CMHC	Percentage
1-4	Counseling Demonstration Tapes (3)	CMHC: A2, A5, A6, A9, B1, C4, C7, C8, C9, D2, D5, D6, D8, D9, E1, E2, F3, G1, G2, G4, H1, I3, K3, K4, L1, L2, L3 Core: 3C	**45% (each 15%)**
1-4	Case Studies (7)	CMHC: A3, A4, A6, A7, A9, A10, B1, C2, C3, C4, C5, C6, C9, D2, D3, E2, E3, E5, F1, F2, G3, H1, H3, H4, K1, K2 Core: 1C, 3C	**35% (each 5%)**
3-4	Topic Presentation (1)	CMHC: A3, B1, C1, C9, D2, D3, E3, D5, F1, K1, K2, K4, K5, L, L2, L3 Core: 1C, 3C	**20%**

A. Description of Assignments

Counseling Intervention Demonstration Tapes

Students will create 3 (three) Counseling Demonstration session tapes. The following format will be followed: 1 sexual concerns; 1substance abuse/use; 1 crisis concerns. Note: There may be additional counseling demonstration tapes assigned if original session does not meet the assignment criteria.

Your counseling Demonstration videotapes should be made with a partner from this class who becomes your "client". As a counselor, you should utilize microskills within a theoretical model you developed in CE 660 for each session with your client. You will begin with an Informed Consent about taping the session and the chosen theoretical framework. Your sessions will be between 30-45 minutes and each videotape will be submitted with a transcript (see below for example).

As clients, students find it difficult to remember details if they are making up material, however they also feel uncomfortable presenting real issues. Two options are: 1) use a real scenario from your history or 2) use presenting issues from someone you know well. Check with your counselor prior to taping to determine your client story based on the goal of the assignment (sexual concern, substance use or abuse, crisis).

You may use electronic devices that enable you to turn in a final product on a flash drive or D2L. Please ensure the following:

1. The microphone is working and voice can be heard distinctly (if session is not clearly audible, it will not be considered for grade)
2. light source at rear or side does not interfere with picture
3. faces and bodies of counselor (and client, if possible) can be seen
4. outside interruptions are kept to a minimum during taping (outside noise, rain, pets, etc.)

Points Possible	***15 points***	***12-14 points***	***10-11 points***	***9 or fewer***
Issue Addressed	Issue is clearly identified and goals are set	Issue is clearly identified and goals are set, but vague	Issue is not clearly identified and goals are not set	Issue is not clearly identified nor addressed, and goals are not set. Session is confusing and disorganized.
Theoretical Model	Exemplary tape illustrating theory.	Above average tape illustrating theory.	Average tape illustrating theory.	Tape does not illustrate theory.
Therapeutic Presence	Student demonstrates empathy, exemplary listening skills, and a variety of microskills.	Student demonstrates empathy, good listening skills, and some microskills.	Student lacks empathy, demonstrates marginal listening skills, and few microskills.	Student lacks empathy, poor listening skills, and no microskills.
Structure of Session	Session is within appropriate time limits – not too long or too short. Student introduces client to session and maintains structure of session throughout. Transcript is completed correctly, with weak statements replaced with preferred statements. Transcript is completed within guidelines.	Session is either too long or too short. Student maintains structure of session throughout. Transcript is mostly correct – few errors – with weak statements replaced with preferred statements. Transcript is lacking for any part of the session.	Session is either too long or too short. Student does not maintain structure of session throughout. Transcript has several errors – with weak statements replaced with preferred statements. Transcript is not well-written or formatted correctly.	Session is either too long or too short. Student does not maintain structure of session throughout. Transcript has several errors – weak statements are not replaced with preferred statements. Transcript is incomplete. Requirements not met.

INFORMED CONSENT

Sample Informed Consent:

I want to take a few minutes to go over (review) a few things. Thank you for signing the permission to tape form. I am taping this session for my training class to get feedback on my skills from my instructor and peers in the class. Mostly they will be focusing on me, not you. But at any time if you want me to turn the tape off, let me know and I will. Do you have any questions?

My theoretical approach to counseling is Motivational Interviewing and CBT. I believe in goal setting and will want to begin every session with a goal to work on within the time frame we have set for ourselves. I will want to focus on your strengths and what is going well for you in addition to subject matter on issues you are struggling with. I may want to plan cognitive and behavioral goals between sessions for you to work on as we focus on an identified counseling goal. We will typically have 25 minutes. I will set up additional sessions at the end of each session depending on your interest in planning additional sessions. Do you have any questions? **Transcribe each tape according to the attached TRANSCRIPT FORMAT. Write on one side of the page only and type. No handwritten transcripts will be accepted.** Please follow directions exactly.

Do **NOT** WRITE THE CLIENT'S NAME ANYWHERE ON THE TRANSCRIPT.

Keep **confidential** what is discussed in sessions.

TRANSCRIPT FORMAT TO BE FOLLOWED

Tape #1
January 14, 2018
Sexual Concerns

Statement	**Skill/observation**
Cl #1: I'm just really confused about….	looking down
CO#1: You sound concerned and angry…	**RF**
Cl #2: I am, I really worry…	crying
CO#2: Tell me more	**Enc**
Cl#3: I just don't know what…	
CO#3: You are worried that...	**RF & Enc**
CL#4: I want so much for…	
CO#4: You should just go ahead and have sex with him	**Ugh! Advice!**
PS: Tell me more about your concerns	**Foc**

Note: Preferred Statements are allowed on all tapes.

Three paragraphs:

Strengths
Areas to Improve
Goals for Next Tape

Case Studies

There are 7 (seven) case studies discussed in class. Case studies will be discussed in class in the following format, and narrative (4 page maximum) summaries will be written and submitted by each student to the D2L Dropbox on assigned dates.

- ***The Client/s*** Your instructor will describe the client's diversity in terms of the following identities: gender, ethnicity (race), disability, class, age, sexual orientation, and religion.
- ***Presenting Issues and Challenges*** Your instructor will offer information on the client's reason for referral, psychological difficulty, subjective distress, and any clinical observations.
- ***Case History and Developmental Background*** Your instructor will offer familial, cultural, social, ethnic, and identities and their contributions to the personality development of the client.
- ***The Therapy*** Students will discuss:
    1. a potential diagnosis
    2. the therapeutic perspectives
    3. the particular approach or modality that could be used with the client
    4. the process of counseling and therapy will be described in some detail, including the following:
        a. interventions; assessment, goals, and therapy treatment; and outcomes.

Students should consider the identities in the clinical process, particularly the use of traditional healing, spirituality, and other alternative healing modalities that support resilience.

- ***Questions*** Students will complete their discussion with 3-5 follow-up questions regarding the case and a plan for how they might obtain information.

Points Possible	***5 points***	***4 points***	***2-3 points***	***1 or fewer***
The Client(s)	Discussion of client identities is strong and articulate	Discussion of client identities is adequate	Discussion of client identities is weak	Discussion of client identities is non-existent
Presenting Issues	Discussion of presenting issues is complete, accurate	Discussion of presenting issues is complete, mostly	Discussion of presenting issues is weak, not	Discussion of presenting issues is non-existent

	and comprehensive	accurate and comprehensive	accurate and not comprehensive	
Case History and Develop-mental Background	Student demonstrates strong ability to summarize case history and developmental background	Student demonstrates some ability to summarize case history and developmental background	Student demonstrates little ability to summarize case history and developmental background	Student demonstrates no ability to summarize case history and developmental background
Therapy	Student articulates a potential diagnosis, appropriate interventions, assessment tools, therapy goals, treatment and outcomes. Students strongly consider the client's identities in the clinical process	Student describes a potential diagnosis, appropriate interventions, assessment tools, therapy goals, treatment and outcomes. Students adequately consider the client's identities in the clinical process	Student summarizes a potential diagnosis, appropriate interventions, assessment tools, therapy goals, treatment and outcomes. Students weakly consider the client's identities in the clinical process	Student does not adequately summarize articulates a potential diagnosis, appropriate interventions, assessment tools, therapy goals, treatment and outcomes. Students does not consider the client's identities in the clinical process
Questions	Students create articulate follow-up questions (3-5) regarding the case and a well thought out plan for how they might obtain information	Students create effective follow-up questions (3-5) regarding the case and a plan for how they might obtain information	Students create weak follow-up questions (3-5) regarding the case and a poorly thought out plan for how they might obtain information	Students do not create follow-up questions (3-5) regarding the case nor a plan for how they might obtain information

Topic Presentation

One literature review and related topic presentation will be completed; students will select a topic within the categories of sexual concerns, substance use and abuse, and crisis interventions. Each presentation will be 20 minutes (including Q&A) with handouts with full APA reference list. **Potential** topics include: counseling for sexual orientation and identity, counseling clients with heroin addiction, counseling clients in crisis following a natural disaster. ***Students MUST pre-approve their topic with the instructor.***

Your Literature Review/Presentation should include the following:

1. **Important distinctive elements about issues related to chosen topic**
2. **Specific counseling issues to be addressed in a counseling session**
3. **How you intend to combine a specific techniques related to the identified counseling issue**
4. **How you plan to integrate counseling for multicultural and ethnic diversity issues**

Points possible	***17-20 pts.***	***14-17 pts.***	***10-13 pts***	***Fewer than 10 points***
Content	Presentation clearly concerned with counseling issue. All aspects of assignment addressed and discussed, and complex thinking skills utilized. Assignment turned in on time.	Presentation clearly concerned with counseling issue. Most aspects of assignment addressed and discussed, and complex skills utilized. Assignment turned in on time.	Counseling issue chosen is not discussed or reviewed well; explanation of is lacking. Some aspects of assignment missing. Some evidence of complex thinking skills evident. Assignment turned in late.	Counseling issue chosen is not clearly defined, discussed or reviewed well; explanation of is lacking. Most aspects of assignment missing No evidence of complex thinking skills. Assignment turned in late.
Format	Exceptional Presentation skills (excellent grammar, flow, structure, & strong synthesis of ideas). A minimum of 7 scholarly references, including the text.	Strong presentation skills (excellent grammar, synthesis of ideas). Minimum of 5 scholarly references, including the text.	Marginal presentation skills, several errors in formatting, grammar, or synthesis of ideas. Minimum reference of 5 not met.	Poor presentation skills utilized, grammar, or synthesis of ideas. Minimum reference of 5 not met.

Depth of Understanding	Strong synthesis of relevant literature; discussion of counseling issue, counseling techniques, and consideration of counseling theory applied are clear and supported by research; and discussion about diversity issues are well developed.	Adequate synthesis of relevant literature; discussion of counseling issue, counseling techniques, and consideration of counseling theory applied are clear and mostly supported by research; and discussion about diversity issues are well developed.	Weak synthesis of relevant literature; discussion of counseling issue, counseling techniques, and consideration of counseling theory applied are not clear, nor supported by research; and discussion about diversity issues are not well developed.	Weak synthesis of relevant literature; discussion of counseling issue, counseling techniques, and consideration of counseling theory applied are non-existent; and discussion about diversity issues is missing.
Presentation Style	Topic is delivered without reading slides; eye contact with audience is engaging; presence is professional; presenter is excited to talk about their topic	Topic is delivered without reading slides for the most part; eye contact with audience is strong; presence is professional; presenter is excited to talk about their topic	Topic is delivered by reading slides; eye contact with audience is weak; presence is not professional; presenter is not passionate about their topic	Topic is delivered by reading slides; eye contact non-existent; presence is uncomfortable/anxious; presenter is bored/boring by/about topic

B. Grading for Course and Policies

- Grade Scale: 100-90 A
  89-80 B
  79-70 C
  69-60 D
- -Taped sessions that do not meet the minimum requirement of each respective assignment may be repeated for a grade. Students may opt to redo a taped session for a higher grade and the highest grade will be recorded.
- -All sessions will be taped outside of class; students should plan accordingly.
- No late work will be accepted.

VIII. COURSE SCHEDULE

DATE	Topic	Assignments and Activities
1.9	Introductions, syllabus, review of microskills and theory, partner selection, desensitization exercises	
1.16	Sexual Concerns	**Hyde and Delamater**: Chapters 4, 7, 8; Orenstein Book **DSM-5** Sexual Concerns: Sexual Dysfunctions, Paraphilic Disorders, Child Sexual Abuse, Other Circumstances Related to Child Sexual Abuse, Spouse or Partner Violence, Sexual
1.23	Sexual Concerns	**Hyde and Delamater**: Chapters 9, 10, 12, 13 Orenstein Book **Case Study #1** **Prepare for Tape #1**
1.30	Sexual Concerns	Hyde and Delamater, Chapters 14 and 15 Orenstein Book
2.6	Sexual Concerns	Hyde and Delamater, Chapters 17, 18 Orenstein Book **Case Study #2** **Tape #1 Due**
2.13	Substance Use and Abuse	Fisher & Harrison, Chapters 1-4 DSM-5, SUDs & SIDs
2.20	Substance Use and Abuse	Fisher & Harrison, Chapters 5-8 Screening & Assessment **Case Study #3** **Prepare for Tape #2**
2.27	Substance Use and Abuse	Fisher & Harrison, Chapters 9-12
3.13	Substance Use and Abuse	Fisher & Harrison, Chapters **Case Study #4** **Tape #2 Due**
3.20	Crisis	Jackson-Cherry and Erford, Chapters 1, 2, 3 DSM-5 Crisis/PTSD: Anxiety Disorders, Trauma-and Stressor-Related Disorders
3.27	Crisis	Jackson-Cherry and Erford, Chapters 5, 7, 8 **Case Study #5** **Prepare for Tape #3**
4.3	Crisis	Jackson-Cherry and Erford, Chapters 9, 10

4.10	Crisis	Jackson-Cherry and Erford, Chapters 11 and 12 **Case Study #6,** **Tape #3 Due**
4.17	Various Topics	Topic Presentations
4.24	Various Topics	Topic Presentations **Case Study #7**

IX. UNIVERSITY EXPECTATIONS & COURSE POLICIES

A. University Expectations and Resources

Diversity Statement: This is meant to be a safe, welcoming, and inclusive classroom environment for students of all races, ethnicities, sexual orientations, gender identities/variances, ages, religions, economic classes, and ability statuses. As such, you will be encouraged and challenged to use language and basic counseling techniques that are respectful, inclusive, representative and culturally appropriate.

Academic Integrity: Students are expected to practice professionalism and academic integrity in all assignments and class discussions. This includes but is not limited to treating other students and the professor respectfully, engaging in meaningful class discussions, thinking and writing critically and thoughtfully, creating original works, and citing all resources using APA format. Plagiarism will result in loss of credit for this course, and further consequences may result from the university system. The collegiate policy on plagiarism and cheating is outlined in the Student Handbook. It is your responsibility to be aware of this policy. You can also find it online at: http://www.winona.edu/sld/academicintegrity.asp.

Electronic Device Notice: As a matter of courtesy to your classmates and the instructor, please turn off your beepers, cell phones, and any other electronic devices that make any noise.

Laptop/PDA Policy: Excluding students with a documented disability, the use of laptops and PDAs in class is prohibited without prior permission of the instructor.

Class Visitor Policy: Due to the clinical nature of this course in this curriculum, visitors of any age are not allowed without prior permission of the instructor.

E-mail Policy: You are assigned a university e-mail account that will be used by professors. Students should make every effort to get to know their account and check it regularly.

Accommodations: Students with documented disabilities who may need accommodations, who have any medical emergency information the instructor should know of, or who need special arrangements in the event of an evacuation, should make an appointment with the instructor as

soon as possible, no later than the 1st week of the term. According to Section 504 of the Rehabilitation Act of 1973, students with disabilities have the right to receive necessary reasonable accommodations and support services to allow equal access at Winona State University. If you have a disability that requires accommodations, you are eligible for support through access services, found at http://www.winona.edu/accessservices/gettingstarted.asp.

Commitment to Inclusive Excellence: WSU recognizes that our individual differences can deepen our understanding of one another and the world around us, rather than divide us. In this class, people of all ethnicities, genders and gender identities, religions, ages, sexual orientations, disabilities, socioeconomic backgrounds, regions, and nationalities are strongly encouraged to share their rich array of perspectives and experiences. If you feel your differences may in some way isolate you from WSU's community or if you have a need of any specific accommodations, please speak with the instructor early in the semester about your concerns and what we can do together to help you become an active and engaged member of our class and community. Campus resources for students: http://www.winona.edu/diversity/estatement.asp.

B. Graduate Student Resources

General Information: Academic calendar, forms and other procedures for graduate students can be found at http://www.winona.edu/gradstudies/currentstudents.asp

WSU-Rochester Student & Campus Services, UCR Room SS128, 285-7100, (www.winona.edu/rochester/):
RCTC Counseling Center, UCR Room SS133; 285-7260 (www.rctc.edu/counseling_career_center/)
UCR Learning Center, UCR Room AT306; 285-7182

Counseling Services: Graduate school can be very stressful. Counselors are available in Winona and through partnership with RCTC on the UCR campus to help you with a wide range of difficulties.

WSU counselors in Winona are located in the Integrated Wellness Complex 222 and they can be reached at 457-5330. The RCTC Counseling Center is located in SS 133 and can be reached at 285-7260.

Other Support Services: WSU-Rochester Student & Campus Services Office and the WSU Inclusion and Diversity Office are dedicated to helping students of all races, ethnicities, economic backgrounds, nationalities, and sexual orientations. They offer tutoring and a wide range of other resources.

The WSU-R Student & Campus Services Office is located in Room SS128 on the UCR campus and can be reached at 285-7100. The WSU Inclusion & Diversity Office is located in Kryzsko Commons Room 122, and they can be reached at 457-5595. Information about the *KEAP Center*, dedicated to supporting diversity on campus, can be found here: http://www.winona.edu/diversity/22.asp.

***UCR Learning Center – Rochester*:** For help with writing and the development of papers on the WSU-Rochester campus, contact personnel in AT306 or call 285-7182.

Writing Center - Winona: The Writing Center offers free, individualized instruction in all forms and disciplines during any stage of writing, reading, or research. Call 507.457.5505 for an appointment. Walk-ins also welcome.

Student Grievances: Students are encouraged to speak directly with instructors when concerns arise. When issues cannot be resolved between the student and the instructor, students have the right to due process. Such complaint procedures are available online at: http://www.winona.edu/sld/studentgrievance.asp

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Case Studies

Case Study #1

The Client/s

Your client is Albert, an African American male, 35 years old, middle class, gay Christian (he attends a local Baptist Church on a semi-regular basis). He works in advertising and has a successful business career. He is confident in his ability to operate in the business world because he is a covert homosexual and brings a female friend to serve as his "beard" to social events at work. He knows he would receive discrimination if he were to be open about his sexuality. Very few close friends know about his sexual orientation.

Albert has a sexual partner, Gerome, he's seen for 10 years and they live in different cities about two hours away from each other. They visit a few weekends a month at each other's homes. When they venture out as a couple, they are usually vising Gerome's town where there is a discreet gay social group with whom they spend quite a bit of time.

Presenting Issues and Challenges

Albert is coming to counseling for the first time based on a recommendation by his physician to see a therapist about sexual difficulties and related depression. His regular sexual partner, Gerome, has been complaining to him lately that his orgasms seem to take forever and sometimes they give up all together during a lovemaking session w/out Albert achieving orgasm. This has led to frustration for both partners.

The difficulty in reaching orgasm occurs with oral and anal sex, and with hand stimulation by Albert's partner. Achieving orgasm via masturbation when alone is not a problem.

Albert is worried about losing his sexual partner and has become obsessed with his issue for about 6 months, thinking about it at work, while working out and when alone in the evenings. He masturbates every day to make sure he can achieve orgasm at least when he is alone.

Albert seems articulate and willing to work on his sexual concerns with you but has trouble identifying exactly when the trouble began and the origin of the sexual frustration.

Other than Albert's sexual concern and worry about losing his partner, he seems relatively jovial and uses humor to deal with his stress. Depressive symptoms include loss of sleep, compulsive eating, low energy and feelings of hopelessness about his sexual concerns.

Case History and Developmental Background

Albert grew up in an urban Midwest town in a family with two brothers and one sister and parents who were happily married. He had been sexually abused when he was eleven years old by an uncle on a summer vacation, when he was forced to perform fellatio on his uncle on several occasions during one visit. The uncle was an infrequent visitor to the family's home so Albert didn't see him alone during later visits. He never told anyone about the abuse and doesn't feel the need to work on this issue.

Albert's family was conservative and operated from a male-dominated familial culture when making family decisions. His father "ruled" the home and was a successful business entrepreneur. His mother was a stay-at-home mom and nurtured the family with love and affection. Albert is most close with a sister, Lilly, with whom he has come close to sharing his sexual orientation, but continues to not share this identity with anyone, except for the female friend, who serves as his "beard" at office functions and friends via the small social network in Gerome's town.

Albert lives a conflicted but relatively peaceful life in that he keeps separate his sex life and his business/social life. He feels the most "himself" when at work as he identifies with his success as an advertising agent. Sometimes, he feels disenfranchised when thinking about how he must live his life in pieces, instead of with cohesion between work and home, like most people.

Albert has a gay support network of friends in the city where Gerome lives, and together they have enjoyed time out with their gay friends. He feels comfortable when spending time with this social network but worries that someone new will connect him to his life in advertising and ultimately blow his cover.

Albert has a structured personality and keeps a clean and orderly home. He structures his work and social activities based on a rigid schedule and enjoys knowing what to expect in life. His recent sexual issues are bothering him most because he can't seem to control something for the first time in his life. He hasn't had a history of depression to date and is confused as to why he is finding himself with depression symptoms at this time in his life.

The Therapy

Students will discuss a potential diagnosis, the therapeutic perspectives and the particular approach or modality that could be used with the client. The process of counseling and therapy will be described in some detail, including the following: interventions; assessment, goals, and therapy treatment; and outcomes. Students should consider the identities in the clinical process, particularly the use of traditional healing, spirituality, and other alternative healing modalities that support resilience.

Questions

Students will complete their discussion with 3-5 follow-up questions regarding the case and a plan for how they might obtain information.

Case Study #2

The Client/s
Your client is Marsha, a Caucasian cisgender 35-year-old woman who has only been with men and considers herself heterosexual, but is attracted to women at times. She is upper middle class, attends the Presbyterian Church in town weekly, and has been divorced for 3 years. She works as a local librarian and loves the quiet life. She's been dating Paul for a few months and although sex is pleasurable, she fakes her orgasms because she doesn't know how to ask for her sexual needs to be met, and she's embarrassed about how long it takes her to orgasm. Even with masturbation, she has trouble achieving orgasm much of the time.

Marsha does not have children and lives in a home paid for by her parents because she was the main breadwinner in her marriage and paid a lot of money out for the divorce settlement, pays for maintenance for her husband and recently took her job to part-time to alleviate some work stress that's been building up. Her parents were happy to help her out and often check in with her to see if she needs anything, financially or otherwise.

After Marsha's divorce, she began taking Prozac, which helped with her depression. Her depression is mild these days, since she has been dating Paul. She's thinking about going off of Prozac, but worries that the depression would return.

Presenting Issues and Challenges

Marsha is coming to counseling now because of sexual concerns and she heard about your reputation for being good with people who have relationship and sexual issues. She was in counseling for her divorce, but her therapist has left town and she was looking for a new counselor.

The difficulty in reaching orgasm occurs with oral sex and intercourse. Paul is unfamiliar with the clitoral and G-Spot stimulation and is uncomfortable with hand stimulation on Marsha, although he expects to receive oral sex, intercourse and hand stimulation from Marsha. Achieving orgasm via masturbation when alone is a problem and she orgasms about 50% of the time. She only reaches orgasm with Paul about 10% of the time.

Marsha feels bad about faking her orgasms with Paul and wants to learn how to talk to him about her needs.

Marsha seems well balanced in terms of her work and social lives, friends and church support.

Case History and Developmental Background

Marsha grew up in an urban Midwest town in a family with three sisters and parents who were happily married. She was and is close to her parents, who dote on her. She had her first sexual relationship when she was 16 with her 16 year old boyfriend who was a supportive and generous lover. Together they explored their sexuality and she was able to orgasm at least 75% of the time with him during intercourse and hand stimulation. During her marriage of 10 years, she had orgasms frequently and enjoyed sex with her husband via intercourse, hand stimulation and oral sex.

Marsha is in competition with her sisters who are both married with children. She feels less than because she doesn't have a family and is divorced.

Marsha has a relaxed personality, but is unsure of how to talk about sex to you and to her new boyfriend. She says she had an easy time of things with her first boyfriend and husband, both of whom were sexually skilled. Her recent sexual issues are bothering her the most because she knows she can typically orgasm, but can't seem to talk to Paul about what she needs.

The Therapy

Students will discuss a potential diagnosis, the therapeutic perspectives and the particular approach or modality that could be used with the client. The process of counseling and therapy will be described in some detail, including the following: interventions; assessment, goals, and therapy treatment; and outcomes. Students should consider the identities in the clinical process, particularly the use of traditional healing, spirituality, and other alternative healing modalities that support resilience.

Questions

Students will complete their discussion with 3-5 follow-up questions regarding the case and a plan for how they might obtain information.

Case Study #3 – Mike

The Client
Mike is a 43-years-old, single, Caucasian, male, lower SES (situational poverty). He is attending your program on an outpatient basis, residing in an adult group home as his primary residence. You are seeing him for a comprehensive diagnostic assessment and treatment planning to place Mike in an appropriate day program.

Presenting Issues and Challenges

Mike can no longer take care of himself independently. He needs to be reminded to perform DLSs, and he is confused about how to operate a washing machine. Although he is pleasant and has an overall good disposition, Mike has difficulty interacting with others. Mike forgets what is being

discussed and begins to make up stories to try to stay in the conversation; unfortunately, the stories have little or nothing to do with the conversation. He rambles and ruminates about irrelevant things (e.g., having to repair the concrete foundation of a home that no longer exists). Mike demonstrates difficulty staying on task and needs frequent redirection during conversations. His abilities to function and comprehend information are impaired. Mike is unable to live independently or to remain sober outside of a controlled environment. His developmental history, below, will inform you as to his somewhat rapid decompensation.

Case History and Developmental Background

Having never married, he lives with his mother and receives Social Security Supplemental Security Income (SSI) benefits. He graduated from high school and has had a few odd jobs doing construction and yard work; however, he has not worked in 15 years. Mike reports he began drinking a couple of alcoholic beverages twice a week when he was 9 years old and began drinking heavily beginning at about age 14. He states that he has not been sober (abstinent) for more than a couple of months at a time throughout his life, and these month of sobriety "have been few and far between."

Mike states he spends his days drinking and panhandling for money so that he can buy more alcohol. He states he wakes up during the night ad has to drink to "stop the shakes" (i.e., delirium tremens). Mike acknowledges that drinking consumes his life but states he "does not really see it as a big problem." He reports that his mother has been increasingly concerned about him.

Mike has been arrest 8 times this year for public intoxication, which is a significant increase from his previous arrest record of once or twice per year for public intoxication. Subsequently, he has incurred numerous emergency department and 72-hour detoxification admissions. When police finally placed him in jail (as opposed to the ED or detox), he could not understand when he was being incarcerated. The medical staff at the jail helped Mike to detox (withdraw) from alcohol and helped him get stabilized on medications. He spent 4 months in jail, and the jail staff report that Mike had some difficulty during his incarceration due to his unwillingness (inability?) to follow basic rules, such as making his bed and maintaining a sanitary cell. They stated it was almost as if he could not remember to do it, rather than blatantly violating the rules. Staff also report Mike fell down frequently. Overall, the jail staff describe Mike as likeable, kind-hearted, and a "good" inmate.

Within three days of his release from custody, he was hospitalized in a psychiatric unit because he was experiencing difficulty with coordination (e.g., walking and getting in and out of a chair) and with memory (e.g., he got lost on the sidewalk in front of his home). Within a week after he discharge he required re-hospitalization for the same concerns. Mike was linked with an outpatient treatment facility and was assigned a case manager. A few days after his second discharge, he was arrested for public drunkenness. Fortunately, the police contacted Mike's new case manager and did not put him back in jail. He was placed in a state-operated, lock-down, long-term treatment facility for 6 months and was then transitioned into a group home.

The Therapy

Students will discuss potential diagnoses, and the therapeutic perspectives and particular approaches or modalities that could be used with the client. The process of counseling and therapy should be described in some detail, including the following: screening and assessment, goals, and therapy treatment; clinical interventions; and anticipation outcomes. Consider ongoing (continuing) care. Students should consider the client's identities (intersectionality) in the clinical process, his presenting issues, and match these to a program that would best fit his presenting needs. Again, consider the integration/combination of services to best support this client.

Questions

Students will complete their discussion with 3-5 follow-up questions regarding the case and a plan for how they might obtain information.

Case Study #4 – Carol

The Client
Carol is a 36-years-old, single, Caucasian, female, lower SES (generational poverty). She presents to your agency as a criminal justice referral from her probation officer for a comprehensive substance use assessment and placement recommendation. Carol has an extensive criminal history involving solicitation, prostitution, public intoxication, and menacing. The referring officer believes Carol's legal issues are secondary to her chronic alcohol use and trauma. Carol has made previous attempts to address her substance use through numerous detox services, treatment episodes, and community support (e.g., AA).

Presenting Issues and Challenges

Currently, Carol resides in a SRO hotel room, which she has used to engage in prostitution. She was recently physically assaulted and brutally raped during a sex encounter for money. She attempted to address the assault in the way that she knew how, drinking to excess (i.e., intoxication, including to passing out). She reports decreased appetite and some concerns of sadness. Her most recent arrest involved public intoxication and solicitation of a law enforcement officer.

Carol did not qualify for drug court as due to her lengthy criminal history and the fact that she was already on probation at the time of her most recent arrest. Yet, her probation officer feels that she might meet success with this treatment attempt. Carol indicates she often drinks more than she intends, and efforts to decrease or abstain from drinking have not been successful. Although she has an extensive history of trauma and a current traumatic event, she does not connect her increased drinking with risk. Carol has few friends and minimal social support. She believes she is beginning to experience conditions similar to those experienced by her mother during her alcohol use.

Case History and Developmental Background

Carol grew up in rural Alabama and was raised primarily by her mother. She indicates her father was never an active participant in her life and that her mother had a number of boyfriends. Carol recalls

that for most of her adolescent and teen age years, her mother was a chronic alcoholic. She recalls numerous episodes of volatility in the household. Carol is the oldest of four siblings and is the only girl of the family. As the elder child, she felt she was 'parentified' at a young age as she took on the role of caregiver to her younger siblings.

Carol reports an ongoing physical (sexual) relationship with one of her mother's boyfriends that began with touching when she was about 10 years old. She began experimenting with alcohol at about this time. Out of fear, Carol did not disclose the sexual assaults to her mother until she was 13 years old, at which time the incidents had escalated from touching to sex. When this information was disclosed, she indicates her mother was accusatory of her and blamed her for the acts.

Carol continued to drink recreationally with friends until she dropped out of school at age 16. During this time, her mother was diagnosed with cirrhosis of the liver, and Carol had her first run-in with law enforcement for underage drinking. She was kicked out of the house at this time.

With little to no resources, Carol began exchanging sex for money and housing. In order to engage in this behavior, she would drink until the point of feeling numb. Having lost all communication and connection with her family, she continued this patterns for many years. After garnering an extensive arrest history and emergency department admissions, to include several 72-hour placements in detoxification, Carol attempts to gain sobriety by engaging in treatment for her alcohol use. She recalls her first attempts at treatment beginning around the age of 24. She has not successfully completed any of the previous treatment episodes.

The Therapy

Students will discuss potential diagnoses, and the therapeutic perspectives and particular approaches or modalities that could be used with the client. The process of counseling and therapy should be described in some detail, including the following: screening and assessment, goals, and therapy treatment; clinical interventions; and anticipation outcomes. Consider ongoing (continuing) care. Students should consider the client's identities (intersectionality) in the clinical process, and particularly the use and efficacy of both standard (i.e., abstinence-based) as well as harm reduction addiction treatment approaches. Also, consider traditional and alternative/nontraditional healing modalities, e.g., spirituality, bodywork, postmodern approaches (ACT, DBT, MBCT, MBSR). Lastly, consider the integration of approaches or services to best support recovery and resilience.

Questions

Students will complete their discussion with 3-5 follow-up questions regarding the case and a plan for how they might obtain information.

Case Studies #5

The Client

A culturally and gender diverse group of 20 students and 5 teachers experienced a high school shooting where 5 people were killed and then the gunman shot himself. The gunman was a Native American senior in high school that had been bullied, experienced depression and had been a loner. None of the 20 students and 5 teachers knew the shooter very well. The teachers had him in classes but there was no real knowledge of the shooter.

Of the 20 students, 6 were female Caucasian and 6 were male Caucasian, 3 were female Native American, 2 were male African American, 1 was male Hmong and 1 female Hmong, and a female multiracial student. All teachers were female Caucasian in an age range of 23-40 years. There were no students with special needs; most students and teachers were heterosexual, except for one female Caucasian and one male Hmong who both identify as gay.

The school counselor referred your client to you. Tracy is a Native American female sophomore, aged 15 years old. She lives near the local reservation and spends much of her time with her tribal community, while she also is active in school activities like band and various academic clubs. Her academic work is excellent and she is on the honor roll. Her mother is a single parent and she has two brothers, both younger than she. Tracy knew the shooter through tribal events, but didn't know him well.

Tracy has a good relationship with her mother and brothers, and feels like a caretaker at times when her brothers need help with homework. The family is upper middle class and her mother works as a physician in the tribal health care center.

Tracy has a large circle of friends and has dated a little, but mostly spends time with her family, her tribal social group and band friends.

Presenting Issues and Challenges

Tracy is coming to see you because her school counselor thinks she needs treatment for her recent depression from experiencing the school shooting. Tracy was in the room next to the classroom where the students and teacher were shot. She heard screams and gunshots. She and several of her classmates and teachers huddled behind the boarded up door for over an hour while they listened to the commotion next door and waited for the police to arrive. She was the one that called 911 and she remembers feeling helpless and hopeless during the shooting.

Tracy has trouble sleeping because of nightmares. She also has been experiencing flashbacks during the day, mostly auditory of screams and the shots of the gun. She is agitated all the time and easily jumps with the slightest noise. She is often distracted and her grades are suffering. Tracy also feels like some of the students are blaming her for her ethnic connection to the shooter. She has heard comments that "you can't trust those Indians". She cries easily and is worried that she will never feel better.

Case History and Developmental Background

Tracy grew up in on the reservation near her hometown for much of her life. When Tracy turned ten years old, her mother moved her family to the town with her school district so it would be easier for Tracy and her brothers to get to school. Her mother also wanted her kids to experience both tribal and American cultures and education.

Tracy's father died of a drug overdose when she was eight years old and it was almost a relief that he was gone. His drug use and depression were difficult to live with. Tracy's mother seemed almost happier since his death since she couldn't help him with his addiction. The whole family rarely talks about her father.

Tracy has helped her mother take care of her brothers, by making their meals, helping with homework, giving advice on various topics.

Tracy has had an outgoing personality until recently. She has many friends and a confident way about her, until recently as she appears more hesitant than confident. Tracy's teachers like her and she enjoys school. She plans to be a physician like her mother and she studies very hard.

The Therapy Students will discuss a potential diagnosis, the therapeutic perspectives and the particular approach or modality that could be used with the client. The process of counseling and therapy will be described in some detail, including the following: interventions; assessment, goals, and therapy treatment; and outcomes. Students should consider the identities in the clinical process, particularly the use of traditional healing, spirituality, and other alternative healing modalities that support resilience.
Questions Students will complete their discussion with 3-5 follow-up questions regarding the case and a plan for how they might obtain information.

Case Studies #6 (Each student will take this client at a different age; every assignment will be shared by students with each other after grading.)

The Client

Dan is a mixed race (his father is Hispanic, his mother is white and African American) 9 year old; 16 year old; 21 year old; 27 year old; 40 year old; 50 year old; 70 year old; 90 year old.

Dan is depressed because of the recent loss of his dog (9 yrs); girlfriend (16 yrs); independence when he was incarcerated for drug dealing (21 yrs); job (27 yrs);
wife (40 yrs); best friend due to a heart attack (50 yrs); health (70 yrs)—he has a cancer diagnosis; wife of 30 years to breast cancer (90 yrs).

Dan grew up poor in southern Texas along with his parents who were unemployed much of the time. His father drank and his mother smoked pot almost every day. He worked hard in school to avoid the

life his parents lived and was a "B" student. Before his respective losses, at each stage of life, he was relatively happy with dysthymia from time to time.

Points of high suicidal ideation:
-At age 9, Dan's dog, Rex was his constant companion for 4 years and sole support (given his only child status and neglect by his parents). Rex got hit by a car and died instantly. Dan buried him in his yard, went to his room and considered using his father's gun to kill himself so he could be with Rex. The only think holding him back was his fear of death.
-At age 16, Dan's girlfriend was his best friend in high school and they dated for a year before she told him she was pregnant with another guy's child. Dan considered driving off a bridge to kill himself and instead got drunk with his buddies. The main thing holding him back from suicide was a friend of his who watched out for him and spent a lot of time with him for a few months until Dan recovered from this loss of his girlfriend.
-He started dealing drugs when he couldn't get a job after high school and was making a good living prior to being arrested and incarcerated at the age of 21. Dan considered hanging himself in jail after the incarceration, and tried to, but got caught by an officer. He was "on watch" after that and participated in counseling.
-After prison (3 years) he had a good job working with a mechanic at a job he liked. At age 27 and after 3 years of gainful employment, Dan lost his job due to the economy. Dan considered hanging himself again, but met his future wife at the hardware store. They started dating and she supported him for a few years until he got his next job.
-At age 40, Dan was caught cheating on his wife with her sister after having a pretty strong marriage of 10 years. She left him and took all of his money and resources. Dan thought of shooting himself because of the guilt and shame he felt, and sat with the gun in his lap for a few hours. Then, he remembered a counselor he had talked to in prison and put the gun away. He made a call to make an appointment with a counselor.
-At age 50, Dan was working at a local convenience store, making a decent living, living alone in an affordable apartment above the store. His best friend and co-worker dropped dead of a heart attack. Dan became very depressed and attempted suicide by driving into a ditch. He survived, was hospitalized and treated for depression.
-At age 70, Dan was married 10 years to Martha and had a good marriage and had been manager at his convenience store for 20 years. He finally felt like life was going well these past 20 years after so many setbacks and depressions. He was diagnosed with bladder cancer. His first impulse was to talk to Martha about his depression. He didn't want to put up with the treatments but he also didn't want to die. He threatened to shoot himself with Martha put him in an inpatient treatment center and he was treated for depression. He went through treatment for his cancer and learned to live with an external bladder.
-At age 90, after surviving bladder cancer and enjoying a 30-year marriage to Martha, she died after a short notice of an aggressive form of breast cancer. He plans to shoot himself next to her grave this afternoon.

His non-existent relationship with his parents has affected his self-esteem, although his success in school boosted his self-efficacy in a number of ways. He played football for a few seasons, maintained a "B" average, befriended a few teachers that became excellent male mentors to him. He

stayed away from drugs more than he was around them. He tried to select friends that were not at risk for violence or drug/alcohol use. He didn't want to turn into his parents.

Presenting Issues and Challenges

Dan is coming to see you in the counseling services office/treatment center/prison counseling services/inpatient treatment. He experiences dysthymia and has been treated with anti-depressants on and off throughout his life (except for when he is 9 years old—he is referred to counseling by his school counselor at 9 yrs old).

Dan has trouble sleeping and experiences regular weight loss and gain. He has recurring headaches, and has been diagnosed with diabetes.

His suicidal ideation is high, he has a plan.

Case History and Developmental Background

Dan grew up poor in southern Texas along with his parents who were unemployed much of the time. He worked hard in school to avoid his parents and kept a part-time job helping the local mechanic while in school. Before his respective losses, at each stage of life, he was relatively happy with dysthymia from time to time.

Dan has had typical and extraordinary developmental tasks and struggled with losses at various points of his life. He has always had support of a few good friends who were life-long. Dan got into drug dealing for a short while and when he was arrested and incarcerated, he decided never to sell or do drugs again. He was able to keep his promise to himself.

He enjoyed a healthy sex life with women and his wives. He was attracted to his first wife's sister, who lived with them and it was inevitable that they would have an affair, which they had, which ended his marriage.

Through a series of setbacks, Dan had a resilient run of coping strategies that his counselors taught him. He also realized that his idea of a suicide plan helped him feel like he had options, even if he never chose that option. He also realized that he really didn't want to die, he just wanted his life to be better.

The Therapy Students will discuss a potential diagnosis, the therapeutic perspectives and the particular approach or modality that could be used with the client. The process of counseling and therapy will be described in some detail, including the following: interventions; assessment, goals, and therapy treatment; and outcomes. Students should consider the identities in the clinical process, particularly the use of traditional healing, spirituality, and other alternative healing modalities that support resilience.

Questions Students will complete their discussion with 3-5 follow-up questions regarding the case

and a plan for how they might obtain information.

Case Study #7

The Client/s

Your client is Monica, a Caucasian cisgender 21-year-old woman who has only been with men (a primary boyfriend for about a year, and a party one-night stand) and considers herself heterosexual. She is upper middle class, attends the Catholic Church in town weekly, and is a business major, in her junior year. She has been working at a local hospital in the business office and hopes to work in medicine in a business capacity.

Monica shares her apartment with four roommates and gets along with them for the most part. She is popular and well liked by many of her friends and faculty. She is a hard worker and focuses on doing well in school.

Monica has not dated for over a year and is increasingly distressed to the point of sleeplessness and increased anxiety for no apparent reason. Her grades are beginning to suffer and she decided to come to counseling for her panic attacks.

Presenting Issues and Challenges

Monica is coming to counseling now because of the recent panic attacks when she is home alone, which is common recently because her roommates have begun seeing and staying overnight with boyfriends and sexual partners.

Her own sexual relationship with her 1-year long relationship was enjoyable enough, but she didn't have orgasms and faked them much of the time. She wasn't really into the sex, but really like Paul, her boyfriend and wanted to make him happy. She was 19 years old when they dated and it ended when he began dating someone else. To deal with her grief of the end of the relationship she got drunk with some friends one night and picked up a guy to have sex. She felt hung over the next day and regretful of the decision, but was able to put the night behind her, never having seen the guy again.

Panic attacks occur at night when she tries to go to bed when no one else is in her apartment. She has trouble getting to sleep and staying asleep. She gets dizzy, nauseous, and nervous. She also has racing thoughts about what she worries about not getting done in terms of school work. On occasion she has nightmares about being physically and sexually attacked.

Case History and Developmental Background

Her father sexually abused Monica, for three years during the ages of 13-16. She tried to tell her mother and Monica was not believed. Her mother refused to talk about it, so the abuse continued. It stopped when her parents divorced. She has not been in touch with her father, but understands he is

remarrying yet this year with 3 potential stepdaughters in the picture, between the ages of 10-17.

Monica grew up in a strict Catholic family with strained relationships with her parents. She was an only child and tried to stay away from her parents as much as possible. She was an honor student in high school, was active as an athlete in soccer and loved hanging out with friends. She never told anyone about the abuse, except her mother. When her mother didn't believe her, she simply buried it and tried to stay away from her father.

Monica had good self-esteem in college and she only recently begin to think about the abuse again when roommates were out of the apartment. She is surprised she is dealing with the trauma of the abuse now because she thought she had buried it pretty well.

The Therapy

Students will discuss a potential diagnosis, the therapeutic perspectives and the particular approach or modality that could be used with the client. The process of counseling and therapy will be described in some detail, including the following: interventions; assessment, goals, and therapy treatment; and outcomes. Students should consider the identities in the clinical process, particularly the use of traditional healing, spirituality, and other alternative healing modalities that support resilience.

Questions

Students will complete their discussion with 3-5 follow-up questions regarding the case and a plan for how they might obtain information.