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Chapter 4—Therapeutic Issues for Counselors

Alcohol and drug counselors, along with other mental health professionals, face a number of challenges and special issues when working with people who have suffered abuse or neglect as children. Like most people, counselors become upset or angry when they hear about children getting hurt or being abused. Some counselors are recovering from substance abuse disorders and were themselves abused or neglected as children, and they may find themselves in a professional situation where they have to confront their own abuse experience and its impact on their lives. As a consequence, counselors who were abused or who had substance-abusing parents may experience feelings that interfere with their efforts to work effectively with adult survivors. For example, counselors may find it difficult to relate to clients effectively and to reach a balance of providing enough—but not too much—support and distance.

Survivors of abuse may pose many relational challenges to the counselor. These clients are often mistrustful at the same time that they need a trustworthy relationship, and a "push-pull" dynamic may result. Counselors may find themselves overly fascinated by and invested in a client's abuse history (sometimes to the exclusion of other life and therapy issues), or they may want to avoid discussion of the abuse for personal reasons. Counselors must be mindful of these possible reactions and develop appropriate strategies to ensure effective care of the client. Because child abuse and neglect reflect the ultimate violation of trust, it is critical that counselors maintain a professional relationship with appropriate boundaries and limitations in place. The counselor must be trustworthy and provide a safe relational context that—in contrast to the client's past experience—presents a unique opportunity for healing.

This chapter reviews some of the challenges posed by transference and countertransference issues with this treatment population and discusses possible secondary traumatization in counselors. The Consensus Panel recommends that counselors establish and maintain clear boundaries from the outset, as well as establishing a "treatment frame." Some of the topics discussed below are basic to good counseling and clinical practice, but it is helpful to review them in the context of treating clients with histories of child abuse or neglect.

Transference, Countertransference, and Secondary Traumatization

The counselor-client relationship is a crucial component of all therapy. Its importance is highlighted in work with abuse survivors because of the nature of the injury caused by the abuse—it was often caused by someone in close relationship to the client, on whom she was dependent, and from whom she should have received care and protection. The counseling relationship is therefore instrumental in providing the client with the necessary support to address and work through issues related to abuse (including substance abuse) while modeling a healthy, nonexploitive relationship.

Transference

Transference generally refers to feelings and issues from the past that clients transfer or project onto the counselor in the current relationship. When clients interact with other persons, they are likely to respond in ways that repeat old patterns from their past. Clients bring the everyday responses and distortions of life into the relationship with the counselor, who, as a professional, can recognize these problems that are interfering with clients' daily functioning (Kahn, 1991). These transference reactions have specific implications for survivors of childhood abuse, who may perceive the counselor as threatening or abandoning in the same way as the perpetrator of the abuse. Conversely, clients may idealize the counselor, seeing him as the warm and loving parent they always wanted.

Clients' feelings about themselves might also affect the relationship. Many survivors have enormous shame and low self-esteem and feel responsible and guilt-ridden about the abuse. This may lead to attempts to distract the counselor from abuse-related issues so that they are not discussed or examined, or to respond to the counselor in ways that replicate the past (e.g., as caretaker, as self-sufficient and not expecting or deserving supportive attention). The counselor must be aware of and prepared for possible responses of this sort and must work to bring them to clients, attention for discussion. The counselor must also avoid replicating relational patterns from the past even if clients expect them and act in ways to encourage them. For example, the counselor should not

allow clients to be overly caretaking toward him, nor should he be so overinvolved with clients that objectivity is lost. These issues are discussed in more detail below in the section "Establishing the Treatment Frame and Special Issues."

Countertransference

Countertransference refers to the range of reactions and responses that the counselor has toward clients (including the clients' transference reactions) based on the counselor's own background and personal issues. Although countertransference occurs in all therapy and can be a useful tool, an unhealthy countertransference occurs when the counselor projects onto clients her own unresolved feelings or issues that may be stirred up in the course of working with the client. If the counselor's own boundaries are not firm, she is more likely to have difficulty remaining objective and may respond to a client's transference reaction with countertransference. This is not the same thing as the counselor's subjective feelings toward the client, which may be positive (if the client is a friendly and attractive person) or negative (if the client has an unpleasant appearance and temperament). For example, if clients act seductively, the counselor may feel uncomfortable or threatened. Counselors must pay close attention to their own feelings to protect their clients and to learn more about them. At the same time, the counselor should keep in mind that the feelings clients evoke in a counselor are likely to be feelings that clients are evoking in their daily interactions with others.

Countertransference occurs when the counselor loses her objectivity and becomes overwhelmed, angry, or bereft when hearing a client's story. In such a situation, the counselor may push a client to deal with childhood abuse or neglect issues before the client is ready--out of the counselor's own emotional needs. For the same reason, a counselor might discourage the client from talking about abuse issues, saying it is not the right time. However, it is very important to let the client determine when and at what pace to work on the issues, especially when dealing with child abuse and neglect. Effective treatment will be severely diminished if the counselor is unaware of her countertransference feelings toward a client. In these cases, the counselor should be closely supervised, or the client may need to be referred to another counselor.

Counselors must also be cautious not to see signs of childhood abuse in every symptom. Because of the high incidence of childhood abuse and neglect among clients in substance abuse treatment and many counselors' earnest desire to help, there is a danger of overinterpreting nonspecific sequelae. Not everyone in treatment has been abused, and counselors should be aware of the possibility of clients recovering nonexistent repressed memories, especially from clients who are eager to please their counselor. (See also the section below, "Avoiding the 'Rescuer' Role.")

It is important for counselors to have a general awareness of these transference and countertransference issues and to be as knowledgeable as possible about their own areas of emotional vulnerability and unresolved emotional issues. This is especially important for counselors who are themselves survivors of childhood abuse or neglect.

Secondary Traumatization

Many counselors find the level of violence and cruelty they are exposed to in working with adult survivors of abuse upsetting and incomprehensible. The counselor who is repeatedly confronted by disclosures of victimization and exploitation, especially between parent and child, may experience symptoms of trauma, such as disturbing dreams, free-floating anxiety, or increased difficulties in personal relationships. He may also experience anger or helplessness, which are detrimental to both the counselor and the client. Or, after a day of dealing with intense material in client sessions, a counselor may seem unaffected until strong emotions emerge--seemingly out of nowhere. The stress and "burnout" that may result from working with such clients can even produce symptoms similar to those of posttraumatic stress disorder (PTSD) (e.g. anhedonia, restricted range of affect, diminished interest, irritability, difficulty concentrating, and insomnia). Counselors can have these reactions even if they have no personal history of childhood abuse.

Counselors experiencing these symptoms may lose perspective and become either over- or underinvested in a client (Briere, 1989; Pearlman and Saakvitne, 1995). Counselors who are underinvested may become numb to feelings that would otherwise cause anxiety, anger, or depression. A counselor may unintentionally, even unconsciously, dismiss, negate, or minimize a client's history of abuse. This reaction represents an attempt to avoid and distance oneself from the uncomfortable issues raised by the abuse. He may respond to the client coldly and clinically. Those counselors who overinvest, on the other hand, become extremely involved with their clients, going beyond the appropriate boundaries of the relationship. They may respond by becoming parental and doing problematic things such as lending their clients money, trying to solve their problems for them, or seeing them too frequently. They may also fail to confront clients when they behave inappropriately or

destructively. When working with a client who was abused as a child, an overinvested counselor may have rescue fantasies or feel inappropriate anger directed at former therapists, child protective services (CPS) workers, and parents or caretakers. In extreme cases, the relationship can cease to be beneficial as it becomes overly personal, with the attendant loss of objectivity that is necessary in a professional relationship (Briere, 1989).

Burnout

As mentioned above, working with clients who have chronic mental health disorders, severe substance abuse disorders, or a history of childhood abuse and neglect can often lead to "burnout." Working with substance-abusing clients who have experienced childhood maltreatment can further challenge a counselor's capacity to remain focused in treatment. Burnout occurs when the pressures of work erode a counselor's spirit and outlook and begin to interfere with her personal life (De Bellis, 1997). These secondary trauma responses have been called "compassion fatigue" (Figley, 1995), referring to the toll that helping sometimes has on the helper.

Burnout affects many counselors and can shorten their effective professional life (Grosch and Olsen, 1994). If the counselor sees a large number of clients (many with trauma histories), does not get adequate support or supervision, does not closely monitor her reactions to clients, and does not maintain a healthy personal lifestyle, counseling work of this sort may put her at personal risk (Courtois, 1988). This situation is even more serious in the current financially focused managed care atmosphere that requires health care workers to assume larger and more complex caseloads. These complex cases often involve previously traumatized clients who present the counselor with many personal and treatment challenges (Grosch and Olsen, 1994).

Counselors can minimize the likelihood of burnout. As much as possible, they should not work in isolation and should seek to treat a caseload of individuals with a variety of problems, not only those who have experienced childhood trauma. Discussing feelings and issues with others who are working with similar clients can decrease isolation through a process of shared responsibility (Briere, 1989).

Counselors also should try to keep a manageable caseload. They should deliberately set aside time to rest and relax, keep personal and professional time as separate as possible, take regular vacations, develop and use a support network, and work with a supervisor who can offer support and guidance. Some treatment settings have established in-house support groups for counselors who work with abuse and trauma survivors. By sharing graphic descriptions of clients' experiences with a colleague, the counselor can gain the crucial support and perspective to be able to continue effective treatment. Working as part of a treatment team can be a natural way to facilitate support and reduce stress.

In some cases, counselors may want to seek personal help through therapy that will allow them to work more successfully with this population. Among its other potential benefits, psychotherapy can help counselors come to terms with their own limitations. Counselors who are satisfied with their personal and professional lives are less likely to experience secondary trauma symptoms.

Establishing the Treatment Frame and Special Issues

Counselors should develop and maintain a *treatment frame*--those conditions necessary to support a professional relationship. Setting and maintaining boundaries is especially critical in treating survivors of childhood abuse and neglect. Several parameters of the treatment frame are discussed below, as well as special issues that may arise. Because childhood abuse is a profound violation of personal boundaries, adult survivors of abuse or neglect may never have developed healthy and appropriate boundaries, either for themselves or in their expectations of others. They often need a great deal of affection and approval, and counselors must make clear that they are not responsible for directly meeting all of those needs. Boundaries help the counselor as well as the client because counselors tend to be nurturing healers, which may lead them to fall unwittingly into inappropriate roles in response to their clients' stories.

For example, a counselor may react to strong countertransference feelings by trying to respond to a client's wishes and expectations. The counselor should guide clients in doing difficult interpersonal tasks themselves, not only to strengthen the clients' ability to take responsibility for their lives but also to maintain important adult boundaries. The counselor must maintain a calm, optimistic interest in his clients, recognizing that getting overly involved will rob clients of the opportunity to identify and build upon their own inner resources.

Other parameters of the counseling relationship, or treatment frame, set by many mental health professionals (Briere, 1989) include

- Making regular appointment times, specified in advance
- Enforcing set starting and ending times for each session

- Declining to give out a home phone number or address
- Canceling sessions if the client arrives under the influence of alcohol or psychoactive drugs
- Not having contact outside the therapy session
- Having no sexual contact or interactions that could reasonably be interpreted as sexual
- Terminating counseling if threats are made or acts of violence are committed against the counselor
- Establishing and enforcing a clear policy in regard to payment

These are general guidelines, and the specific arrangements between a counselor and client will vary according to a number of circumstances. For example, a client may arrive under the influence of drugs or alcohol. Although the counselor will not conduct therapy, he should make sure the client doesn't leave the office and drive a motor vehicle. Also, for some clients, telephone contact outside the therapy session is necessary and fosters a working alliance between client and counselor. Some clients may need ongoing support for dealing with difficulties with their children or suicidal feelings. A rigid rule stating no contact outside of therapy may be harmful for very needy clients. Clients may feel abandoned if a telephone call is not returned, damaging the therapeutic alliance.

In smaller communities, a counselor may expect to encounter clients in public places. It is wise to discuss in advance with clients the confidentiality and boundary issues that could arise in these situations. Clients may prefer that the counselor not acknowledge them or may wish to be greeted with a simple hello. Addressing such issues in advance ensures that the client will understand the counselor's behaviors and will not feel ignored or abandoned.

Building Trust

Building trust has been described as the earliest developmental task and the foundation on which all others are built (Erikson, 1980). Establishing trust is broadly accepted as fundamental to the development of a therapeutic relationship. However, because adults who were abused or neglected by their parents have experienced betrayal in their most significant relationships, they often find it difficult to trust others. Clients who were not abused by persons close to them also experience problems with trust, but for those who have been betrayed by people on whom they were dependent, issues of confidentiality and privacy are especially critical. Trust makes an individual vulnerable to criticism, abandonment, and rejection. Clients may therefore be mistrustful and suspicious of the counselor, making the development of a trusting relationship a potentially long and difficult task. Reflecting the transference discussed above, they may fear the counselor or see him as abusive, manipulative, or rejecting. The counselor must not personalize these feelings but be consistent and reassuring, never taking trust for granted (Courtois, 1988).

As clients deal with childhood abuse and neglect issues, they may face a series of crises. These crises give the counselor opportunities to build trust. In such situations, the counselor can remain consistent and available, helping to allay clients' fear of abandonment and rejection. Many tenets of a good therapeutic relationship (unconditional positive regard, a nonjudgmental attitude, and sincerity) are also essential for establishing a foundation of trust.

When the Client "Falls in Love" With the Counselor

Because of the difficulties many abused clients have with intimacy, the new experience of having someone who listens and whom they can trust can sometimes lead them to believe that they are in love with the counselor. Sadly, many survivors of abuse are so accustomed to negative feelings (shame, fear, guilt, anger) that positive feelings (joy, trust, contentment, playfulness) are unfamiliar to them. Such clients may not understand their own feelings, and they may not have the skills to differentiate them. In some cases, if a client has recently stopped abusing drugs or alcohol, romantic obsession or sexual fantasies can substitute for the substance addiction as a way of reducing tension. Powerful romantic feelings may be directed toward the counselor, threatening the therapeutic relationship.

The counselor may first become aware that a client is having strong transference issues by subtle changes in the client's demeanor or by more obvious signs, such as requests to see the counselor in a nonprofessional setting. The counselor must, above all, avoid transgressing the boundaries of the relationship and continue to emphasize the guidelines discussed when the counselor established the treatment frame. He should not consent to personal requests, even if they seem innocent (e.g., having coffee or going shopping together). Second, even if he only suspects a client of harboring sexual feelings for him, he should immediately bring the matter to the attention of a colleague. This consultation will serve not only to protect himself, should legal complications arise later, but can also help him work through the difficulty in the therapeutic relationship itself.

If the counselor senses that a client is developing romantic feelings for her, she can try to discuss the matter openly by asking questions, such as "I sense that you are feeling very strongly about something today. Is there something in particular you want to talk about?" If a client eventually discloses romantic or sexual feelings, the counselor must maintain a therapeutic stance and uphold the boundaries of the client-counselor relationship. Clients should be encouraged to examine the feelings rather than act on them. The tension of this interaction can lead to a "teachable moment" in which the client learns to better differentiate his feelings. The counselor should remind the client repeatedly of the purpose of their sessions, emphasizing what she and the client will and will not do as part of the relationship. Clients often substitute an attraction to the counselor for an attraction to the abused substance as a way to avoid dealing with unresolved feelings or emptiness.

Another, less confrontational way to deal with this type of situation is to maintain the boundaries of the client-counselor relationship but to use clients' feelings to help them discover solid but non-sexual relationships with people who listen. The client can be assisted to differentiate feeling good from feeling sexual desire. The counselor can explain that the "attractive" aspects of their relationship, such as trust and feeling safe, are qualities that clients will want to look for in their personal relationships.

Similar problems of inappropriate attachments and boundary issues can occur in group therapy, and counselors (whether as group leaders or in separate individual counseling) must be prepared to work with their clients on this dynamic. Here, too, a treatment frame should be established at the outset that addresses interactions between group members and between the group leader and members. Clients should avoid letting any of these relationships become too personal and should be made to understand why, in this setting, developing sexual relationships would be counterproductive. Counselors, in turn, must understand and support the bonding that occurs when clients make disclosures in a safe and sympathetic environment—and the confusion group members may have about their feelings of dependence on or responsibility for other group members (Valentine and Smith, in press). These are therapeutic issues to be addressed in the group that can contribute to the clients' healing from the effects of abuse (Briere, 1989; Courtois, 1988).

The counselor's reaction to attempts at seduction

Because of low self-esteem, incest survivors (or other survivors of abuse) may feel that the only way they deserve a relationship with another person is if they offer sexual involvement (Courtois, 1988). If a victim of sexual abuse acts seductively toward the counselor, the counselor should understand that transference issues are in operation and that the victim is trying to sexualize the relationship. Unfortunately, some counselors do become sexually involved with their clients, thus exploiting the counseling relationship and violating the trust the client has placed in them. Such behavior is unethical, unprofessional, and in some States, illegal. Counselors who become sexually involved with clients may be reenacting the role of victimizing caretaker. Most treatment programs have policies prohibiting such behavior and will fire staff members who violate these policies. In addition, they are likely to register a complaint with the State licensing agency; professional associations will censure or expel members who have sexual contact with clients. In some States, sexual contact with clients is illegal, and counselors will be prosecuted.

Some in the treatment field believe that males should not treat female survivors of male sexual abuse. Although some women may feel safe only with a female counselor, many male counselors can provide effective treatment if they give adequate attention to abuse issues and their own reactions to clients. Furthermore, sensitive handling of the case by a male who does not exploit the client can provide a new, positive male role model. Whenever possible, the client's preference regarding the counselor's gender should be respected; unfortunately, many facilities do not have adequate staffing to allow choice. In such situations, it is important to openly acknowledge the client's feelings and validate them as understandable reactions. This can reduce feelings of helplessness and help prevent the client from leaving treatment prematurely.

Dealing With Disruptive or Dangerous Behavior

Clients in treatment for substance abuse may act rebelliously or violently, a situation that can be exacerbated by an undisclosed history of child abuse. Counselors working with this population have sometimes been victims of physical assault or other violence by clients. It is the program's responsibility to be aware of and inform counselors of any client's history of violence (which may be more common among adolescents in substance abuse treatment). Counselors should have a personal safety plan, and policies should be in place that require them to call law enforcement and press charges if they are threatened.

As well as taking steps to ensure their own safety, it is the responsibility of counselors to create and maintain a safe environment in which clients can explore and address issues. It is the client's responsibility to behave in ways that do not threaten others either physically or emotionally. Early in treatment—at the very outset, if it is a

group setting--counselors should communicate and enforce ground rules about how clients can safely and appropriately deal with anger and other feelings of discomfort. Knowing what is expected of them and the other group members contributes toward their experiencing the group as a safe place to share and be heard. Ground rules should include maintaining members' confidentiality and not sharing any information outside the group, no threats or acts of violence, no verbal abuse, no interrupting other members, and no disruptive behavior. Counselors can help clients learn how to express their feelings constructively by validating their *affect* but not their *expression* (if it is abusive or violent).

Abuse survivors commonly are concerned about their safety--or their potential reactions to others--while reliving painful events. Counselors can help clients face these feelings by reinforcing the present safety of the counseling environment. In a calm voice, the counselor should ask clients to explore rather than act out anger or disruptive behavior. The goal is to emphasize to disruptive clients that their feelings are acceptable as long as their behavior remains appropriate. Clients are allowed to have angry feelings--and verbally express them--but they are not allowed to hit anyone, to throw things, or be otherwise violent or disruptive. In this way, clients can be helped to separate their feelings from their actions. The counselor may find that some individuals become caught in obsessive loops, unable to let go of the precipitating issue or to stop being angry. In some cases, this can indicate hidden problems that may need to be explored further (i.e., for possible referral to a qualified medical or mental health professional), such as obsessive-compulsive disorder, PTSD, or bipolar disorder. Constant rage can be a symptom of manic depression or bipolar disorder.

Counselors can help create a safe atmosphere for clients and reduce acting out by practicing "grounding" techniques such as the following:

- *Anchoring/grounding*: Have the client sit in a relaxed posture in a chair with eyes closed (or open, if he is uncomfortable closing them), focusing on his breathing. Ask him to concentrate on feeling the chair supporting his weight and the floor underneath his feet. Have the client recognize how grounded he is in the present. No matter how anxious he may become reliving moments from his past, he is still safe and grounded in the present. (The counselor should be aware of the hypervigilance characteristic of abused clients and not make any sudden moves, or get up out of a chair while the client has his eyes closed; the issue of personal safety is paramount for most of these clients.)
- *Mirroring*: Practice breathing techniques with the client, having her synchronize her breathing with yours. These techniques will relax the client. (This exercise may have intimate overtones that could confuse clients with transference issues, and counselors should be selective in its use.)
- *Timeout*: To stop the current action or behavior pattern, allow the disruptive client to leave the room for a few minutes.

The counselor must take care to avoid joining in the client's disruptive behavior in any way. Disruptive behavior can best be contained if the counselor stays in his role, maintaining calm, comforting, reinforcing behavior that is appropriate for the approach and setting. However, it is appropriate to use authority and security personnel when physical harm is threatened.

Avoiding the 'Rescuer' Role

Because of strong countertransference reactions, coupled with a desire to meet clients' needs, the counselor may want to defend or "rescue" clients. He may offer too much advice or even concrete assistance, viewing clients too narrowly only as victims of mistreatment. A counselor who is not self-aware or does not hold himself accountable for his own personal emotional health may feel that he is the only one who really knows or understands his clients. He attends too many meetings, provides sponsorship, helps clients with child care, lends them money, or dismisses fees.

Counselors must deal with their own strong feelings in an environment separate from the client-counselor relationship so that they do not confuse their own issues with the clients'. If the counselor notices that she is being placed in the "rescuer" role, it is recommended that this be directly addressed with the client. A client may in fact be comfortable in the victim's role and try to manipulate the counselor to intervene and rescue her in a variety of situations.

If the counselor does take on the rescuer role, clients do not learn about personal responsibility and how to deal with resolving conflict and issues on their own (see Whitfield, 1993). Furthermore, clients may become angry when a misguided counselor crosses the line without the clients' permission by intervening in family relationships in an attempt to rescue or defend them. When this happens, the counselor not only has lost the ability to help his clients but also is likely to cause additional harm. Rescuing may give the counselor a temporary relief from her own feelings of helplessness and anger, but it does not lead to positive outcomes for the clients. Clients will best

be served by facilitating the development of empowerment. This may mean that the counselor allows clients to flounder at times.

Clients may sometimes report becoming involved in relationships that are clearly dangerous from the counselor's perspective. This often reflects the tendency for abuse survivors to be assaulted or abused again after the initial incident or period of abuse. Although the counselor may be tempted to directly advise a client against such a relationship, it is far more useful to work with the client to explore any propensity to excessive risks or self-endangerment. The counselor's role is to help clients understand their vulnerability to revictimization and to empower clients by helping them recognize that they have the ability to set boundaries with others and no longer have to remain victims. Rescuing clients will not serve the longer term purpose of helping clients develop personal respect and safe boundaries free from abuse and violence. (See TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT, 1997b].)

Recognizing Professional Limitations

The counselor must recognize when she is unable to work with a specific client. She cannot benefit clients who are abuse survivors if their issues cause her personal difficulties to the point where her own effectiveness is compromised. Any counselor working with adult survivors should seek support and some form of supervision to review her feelings about the issues brought up by her clients. At the same time, it is the agency's responsibility to ensure that clients are receiving adequate, professional care. From an ethical standpoint, it is better for counselors not to work with abuse survivors at all than for them to take on such challenges if they are not yet equipped to deal with these issues.

If a counselor cannot work with a particular client, he should refer the client to a counselor who is better suited to that individual's needs. Such transfer must be done after discussion with the client, and any issues that arise as a result of the transfer (such as the client's possible feelings of rejection) should be addressed in therapy, both before and after the move. It may be advisable to get an understanding in writing that states that the client knows that treatment with that counselor has ended, at least for the time being. This closes the contract, may lessen abandonment issues, and can help protect the counselor if the client later claims abandonment.

Responsibility of the Agency To Support the Counselor

Alcohol and drug counselors are often subject to great stress. They can be expected to function well and provide effective treatment only if their agency's leadership gives them the appropriate support. Such support includes recognition for and appreciation of the role of the counselor and the stresses it entails. As noted throughout this chapter, this is especially important when counselors are treating clients or families who have a history of child abuse or neglect, because the complexity and number of issues increase, as does the number of systems that must be dealt with. The agency's leadership should strive to impart a sense of vision to staff members that communicates how important their work is as part of the larger effort to break the cycle of abuse and neglect and their impact on society.

The Consensus Panel makes the following recommendations about how the agency can support the counselor:

- Provide a sense of mission.
- Provide (or facilitate) ongoing clinical supervision—if possible, by someone with a specialty in the area of child abuse and neglect.
- Provide trauma training to the counselors that standardizes the procedures for handling trauma cases.
- Empower staff members by encouraging them to share their ideas on improving the program and incorporating, as appropriate, those ideas that enhance the stated mission of the agency.
- Support staff members in their efforts to stay within the limitations of their roles so that they do not take on responsibilities likely to lead to burnout.
- Support staff members in their efforts to keep caseloads at manageable levels and, at the same time, work to educate managed care about the drawback of limiting the length or intensity of services.
- Model the supportive role that the agency wants the counselors to have with their clients.
- Allow counselors unstructured time to talk to each other to give and receive support.
- Train staff on such topics as new assessment tools, research findings, suicide intervention, crisis and nonviolent management of assaultive behavior, and liability issues related to abuse and false memory accusations.

- Bring in an outside professional occasionally to hold a group session with the staff (this can encourage staff members who have been holding in or minimizing the impact of their work on themselves to open up).
- Recognize and reward the work of the staff on a regular basis (e.g., award ceremonies to recognize ongoing and special contributions).
- Hold regular social events (e.g., picnics, softball games).

If staff members are given opportunities to grow, they will stay motivated and will be less likely to burn out. The agency can provide ongoing training to increase counselors' expertise in specific areas, such as preventing relapse and dealing with stress. It is important to solicit input from staff members on what issues are compelling to them—asking, for example, what they perceive to be the sources of their burnout, then get their recommendations regarding how to address it most effectively; they are often the best resources in this situation. Administrators also need to be familiar with managed care guidelines and other funding streams to ensure adequate income for the agency to support the treatment staff and the services it provides. The process of involving staff members in resolving the problem may help to empower them—which, in and of itself, can be a corrective measure. A flexible organizational structure that encourages an atmosphere of mutual purpose can help reduce turnover rates, increase staff morale, and contribute to a program's total effectiveness.

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