



The Counseling & Social Work Superstore

"# 10 ETHICS - CRISIS MANAGEMENT, ASSESSMENT AND DECISION MAKING"

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Peachtree Professional Education, Inc.

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#10 ETHICS - CRISIS MANAGEMENT, ASSESSMENT AND DECISION MAKING

3 CEU Credit Hours

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NOTE: This PeachTree Professional Education, Inc. Online CEU Course entails this packet of information, and also requires reading of your corresponding professional association's Code of Ethics. (External internet links are provided within this course material.)

Course Description:

This course covers assessment practice during crisis situations, working with suicidal clients, documentation of accepted protocol, diagnosing post-trauma clients, helping children who have experienced crisis, and provides a model for making difficult ethical decisions.

Course Objectives:

At the conclusion of this course, the professional will be able to:

1. Identify ethical dilemmas unique to crisis counseling.
2. Understand how to minimize liability in high-risk situations.
3. Develop critical crisis management plans and implement post-crisis resolution strategies.
4. Use your respective association's Code of Ethics to create a foundation for resolving ethical dilemmas.

Purpose of this course:

The purpose of this continuing education course is to provide a current understanding of issues relevant to the mental health counselor concerning providing ethical treatment in times of crisis. This course covers assessment and diagnosis practice, working with suicidal clients, documentation of accepted protocol, post-trauma clients, children who have experienced crisis, and provides a model for making ethical decisions.

Course Outline:

Part 1: Course organization, Documentation and Introduction.

Part 2: Reading of the course materials (this document)

Part 3: Reading of your corresponding professional association's Code of Ethics

Part 3: Administration and Completion of the Evaluation of Learning

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3 Clock Hours / CE Credits



If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree at (800) 390-9536**.

Your instructor is **Richard K. Nongard**, a Licensed Marriage and Family Therapist, Certified Clinical Hypnotherapist and a Certified Personal Fitness Trainer.

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INTRODUCTION

A note from your Instructor...

Perhaps more than any other Ethics CEU course, the content of this particular course is highly important - and actually useful in a practical way. In professional education settings, we often talk about crisis management, and then we also talk about professional ethics, but rarely do we talk about the two together. In the context of crisis management, the subject of ethics is intensely important, because probably in no area of counseling are we as likely to face liability-related issues as when dealing with individuals and families who are in crisis.

Additionally, one of the difficulties in crisis intervention is often choosing which treatment options to employ. Anytime we provide assessment services, and we err in that assessment, we will always provide the wrong interventions. A firm foundation in understanding the process for resolving ethical dilemmas and providing ethical treatment is certainly worthy of its own discussion in the context of professional ethics. My hope is that through this course you will obtain some ideas that can help you to both manage liability and provide the correct interventions for your clients who are in crisis.

Throughout this course, we will look at some issues related to suicidal clients, the treatment of post-traumatic stress disorder and helping children cope with crisis, and we will outline a strategy for resolving ethical dilemmas in the context of crisis management. We will overview nine key elements for crisis-counseling, which not only provide a firm foundation for creating quality interventions, but also, when employed, can help protect a professional from liability-related issues.

I hope you find the content of this course useful for both yourself, and the clients that you serve.



~ Richard K. Nongard, LMFT/CCH

READ YOUR CODE OF ETHICS

Each professional association has published a Code of Ethics. The National Association of Social Workers, the American Association of Marriage and Family Therapists, The American Psychological Association, The National Association of Alcoholism and Drug Abuse Counselors and the American Counseling Association have all published Codes of Ethics unique to the professions that they serve. In addition, various state boards have published their own Codes of Ethics, applicable to licensed individuals in their state.

As part of this course, you are required to read your respective professional association's Code of Ethics. Most professionals will find a copy of the Code in their membership information packets.

For professionals who are licensed but not dues paying members of any professional association, please know that each professional association's website has their Code of Ethics published on the Internet, available for all to read.

From a liability perspective, it is important to note that whether we are a dues paying member or not of our respective professional association, **in civil court we will be held to our professional association's ethical standards.**

For example, if you are a Marriage and Family Therapist licensed by the state but not a member of the AAMFT, you will still be held to the ethical standards of the AAMFT for the services that you provide. If you are a Psychologist and not a dues paying member of the American Psychological Association, in civil court you will still be held to the ethical standards of your respective professional association's Code of Ethics.

When we face ethical dilemmas in our clinical practice, the answers to those dilemmas are often found in the basic principles of professional ethics provided by our professional associations.

- **The Codes of Ethics links below are provided for your convenience.**

Before or after you read the remaining course materials, please select the link for the association that corresponds to your professional licensure, and read their Code of Ethics.

When you take the link - **you will leave this document** - you can use your browser's < back arrow to return, or you may wish to save this file in your Favorite Places. For most professions, the Code reading will be approximately 10-20 pages.

Sometimes the Boards will move or change their links. If this happens, you can find the new link to your Code by using an Internet Search Engine, like www.google.com.

NAADAC - National Association of Alcohol and Drug Abuse Counselors
<http://naadac.org/documents/index.php?CategoryID=23>

NBCC - National Board of Certified Counselors
<http://www.nbcc.org/ethics2>

APA - American Psychological Association
<http://www.apa.org/ethics/>

ACA - American Counseling Association
<http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx>

AAMFT - American Association of Marriage and Family Therapists
<http://www.aamft.org/resources/LRMPlan/Ethics/ethicscode2001.asp>

NASW - National Association of Social Workers
<https://www.socialworkers.org/pubs/code/code.asp>

NINE ELEMENTS OF CRISIS COUNSELING

Before we move on and begin talking about some issues specific to suicide and assessment of crisis diagnosis, and before we also take a look at the model for outlining the resolution of ethical dilemmas according to professional associations, I want to talk about nine basic elements of crisis counseling. It is essential for us to be attentive to these issues during the course of providing services in crisis counseling.

We got in this field not only because we didn't have to take math to get the degree, but because we also like helping people to make positive changes.

I have found that most mental health professionals are giving, caring people who are generally interested in the lives of others. As a result, when clients come to us in a time of crisis, it is often easy for us to respond to the emotions of that crisis, or for us to become emotionally involved in the crisis itself. Being aware of these nine essential elements in the crisis-counseling process can help us to stay focused, despite our emotional response to the very real human crisis that our clients are experiencing.

These nine elements are not in any particular order; they are simply nine elements that I think the professional must be attentive to while providing any crisis counseling services.

The basis for professional ethics is simply 'the quality delivery of services,' and incorporating these nine elements of crisis counseling into the work that we do can truly go a long way toward helping us meet our client's needs.

The first element of crisis counseling is education.

I have never met anybody yet who came to us the way I wish they were. Instead, clients come to us simply the way they are, and they usually lack two things: 1) specific skills to resolve a crisis or a difficult situation, and 2) they usually have cognitive errors, or lack of realistic perceptions.

In order for us to be effective in helping clients resolve crisis situations, the first thing that we often need to do is provide basic education and teach specific skills. For example, if the client loses their job, and this is an emotional and social crisis for them, we often must spend time teaching our clients the skills necessary for gaining new employment. For some clients, this could even include basic patient education, such as job-readiness training (JRT), creating a resume, or even how and where to go about looking for a job.

Having specific skills to resolve crisis events is vitally important. A death in the family can certainly be a catastrophe. Perhaps the surviving spouse lacks the basic financial skills to manage and handle funeral arrangements, insurance,

checking and savings accounts, and payment of debts. In this situation, those basic skills will need to be, in order for them to be able to resolve their crisis.

Sometimes we are not able to teach the specific skills our clients need, and so referral to those who *can* provide these basic education services is essential.

Additionally, our clients often have cognitive errors and believe irrational things. For example, clients who are suicidal often believe that their problems are inescapable, intolerable, and interminable (what I call the three I's of the suicidal person's unrealistic perceptions). While problems may feel inescapable, and while problems may be long lasting, and while problems may be discomforting, the truth is: nothing lasts forever. Therefore, our client's cognitive errors must be confronted.

There is a three-step process that I have found helpful to deal with client cognitive errors: Recognize, Remove and Replace.

The first step is to help them **recognize** that what they believe is simply not true. Confrontation, creating new experiences for the client and helping them to see themselves in the lives of others, are ways to help our clients recognize their cognitive errors.

The second stage in addressing cognitive errors, once our clients recognize that what they believe is true is not true, is to help them **remove** these old ideas. The only way I know to remove old ideas is through the third stage in this process: **replace** those old ideas with new ideas.

I have always done a lot of work with substance abusers, and a frequent intervention I use is to give them a dry erase marker (except for the inhalant abusers, of course). I give them dry erase marker and instruct them to actually write the counters to their cognitive errors on their bathroom mirror. Using sticky notes and tacking them to refrigerators, car dashes and office spaces is also helpful.

This is an effort to replace their old ideas with new truths. And yes, sometimes the never do buy into them. However, when those new ideas stare them in the face each day, in their own handwriting, especially when they first wake up in the morning, many clients will eventually decide to test and find out if what they have written is true. For some of my clients, this has been a simple yet powerfully effective way to help to remove old ideas by replacing them with the truth.

Education should be the first step in the counseling process. I have always liked those shiny AA 12-step bumper stickers that say things like, "This two shall pass," "One day at a time." Even when I have clients who aren't involved in a recovery program, I like to teach them these kinds of mantras or slogans from

the 12-step programs, because they can often go a long way towards helping my clients to remove and replace their old ideas with new cognitions.

The second element of crisis counseling is anger management.

Anger is an energizing emotion. We often think of anger in context with negative emotions and therapeutic difficulties. In Kubler-Ross's five stages of grief, the first stage is shock or denial, and then clients quickly move to the second stage, which is anger.

Many of us, in our traditional therapeutic framework, have been taught to help our clients eliminate their anger. But what Kubler-Ross's outline tells me is that anger is a normal emotion during a time of crisis. When doing crisis counseling, I think it is important for us to approach anger differently and to teach our client to use it constructively.

What are the positive aspects of anger? Anger is a motivator. During a time of crisis, anger can be an energizer and a motivator that helps a person get tasks done, even when those tasks are perhaps so overwhelming that they otherwise would not have the ability to do them.

We also need to recognize that our clients may experience a wide range of other emotions. I am making the presumption that those taking this CEU course are the 'healthy ones,' and that we have a pretty good vocabulary list. We are able to attach descriptive adjectives to the emotions that we experience, and we are able to describe those emotions to ourselves and to other people.

However, clients in crisis often lack the ability to communicate their feelings to those around them, because they don't have the adjectives necessary to communicate the depth of their pain, difficulty, trauma, or tribulation in a calm, rational manner. Consequently, they act out the emotions they experience, which is, in fact, a normal process and part of dealing with clients who are in crisis. So, one simple thing we can do to assist our clients is to teach them the descriptors or the adjectives that describe human emotions. The "Feelings Chart" often found on therapists' walls is a tremendous tool for clients who are in crisis.

The third element of crisis counseling is drawing on our client's strengths.

During any period of difficulty or crisis, there are 'balancing factors' - the strengths that are available to our clients to assist them in solving problems. I have probably never conducted an educational workshop where I haven't talked about the importance of using our client's strengths as a foundation for helping them make change, and with our clients in crisis this concept is absolutely essential.

Our clients have so many problems and so many things wrong with them during a time of crisis that it will be impossible during the course of therapy, even intense therapy, to fix all of those problems. We can't make dead people come back to life. We can't make economies different. We can't change the past. We can't alter consequences or the severity of those consequences in many situations, nor can we make the misery of our clients experiences go away.

However, what we do have the ability to do is take our client's strengths and resources that are available to them during the time of crisis (personality traits, possessions, education, support persons, etc) and use them to problem solve.

Let's take the crisis of job loss for example. What are the client's strengths? There are some clients who have no car, have no phone, or seem to have few job skills, but they do still have at least *some* things that are right with them. "Tenacity" is one such example, as is the ability to communicate with other people, and the motivation (either internal or external) to find new employment. You may have to dig a little, but everyone has some strength or resource that can be utilized to help resolve the crisis - even if that resource is only *you*, and your ability to provide education or hook them up with other referral sources.

I have worked with other individuals who have lost their job and have discovered that they did have many strengths available to them. Perhaps they did have a car and they did have a resume and they did have professional license. And in addition to these strengths, all of our clients have internal resources; the things that make them healthy people. They may have a plethora of problems, but they also have a plethora of internal strengths. Is your client loyal, trustworthy, helpful, friendly, courteous, kind, obedient, cheerful, brave, clean, and reverent? These are examples of true tools in the problem-solving process, and are actually interventions that can help your clients in a time of crisis.

However, our clients might not instinctively draw up on their resources in a crisis situation, if they cannot identify and recognize them. Sure, they recognize the reality that crisis is difficult, but we must also help them to define themselves by their strengths rather than only their deficits. This can be a powerful tool for helping our clients to make change.

The fourth element of crisis counseling is control issues.

When our clients come to us in crisis, they often come believing that they have control over situations that they do not have true control over, or they come to us dependent on controlling those who they are unable to control.

The motivation for a client's suicidal ideation is often not the desire to die, but rather the desire to impact other people or to communicate a message.

What is it that your client truly has control over? Being able to help your client sort this out is an essential task in the crisis counseling process.

I frequently ask clients in crisis to get out a piece of paper and write down, in detail, the crisis they are facing. Now, even when I ask them to write down *all* of the things that are bothering them, they usually only take up a quarter of a piece of paper.

I then ask them to look at the crisis as they have described it: the people, the events, the situations, the outcomes, the fears. Then I ask them to identify all of the people and all of the events relating to the crisis - that they truly have control over.

My clients will usually stare at the paper for a few minutes before they look up and say, "Nothing, no one, not a thing." A few clients, who have extraordinary insight, may say, "The only thing I have the ability to control on here is me and my response," which, of course, is the correct answer.

I use these written exercises to help my clients realize that during that time of crisis, they, themselves, are often the only one they have any true control over. And consequently, if they would focus their time and energy on developing their own healthy responses to crisis, rather than trying to change others, it would help them to resolve the issues far more easily.

The fifth element of crisis counseling is stability.

For the most part, those taking this CEU course are licensed, degreed, employed, mental health professionals. If you unemployed, it is probably because you are retired or because you have chosen to take some time off to pursue other interests. *We* have a tremendous amount of resources. *We* have a tremendous amount of education. *We* are fortunate. I believe that, because of our position in life, it is often easy for us to have and make healthy choices. It is easier for us not to drink to excess, it is easier for us not to do drugs, and it is easier for us not to take out a gun and point it to our heads.

Why? The reasons are very simple: We have a job, we have a car, we have a dog, and we have friends. We have many of the things that our clients do not have; what we have, by virtue in our positions in life, is stability.

When providing crisis-counseling services, we need to look at our client's stability and consider it in our assessment and intervention process. I would like to throw in that stability and a high standard of living are not necessarily the same. I have seen some people who live in \$300,000 houses and drive \$75,000 cars, who are mortgaged to the hilt and can't pay their bills at the end of the month. I have also met people who live in a paid-for mobile home and drive an old car that barely gets from one side of town to the next, whom I

consider far more stable. Stability has very little to do with the specific things that we have, but rather the safety and security of the environment we are in.

The individual in the mobile home knows that they can afford the \$150 monthly lot fee. The person on the \$300,000 house may be very worried about their \$2,800 mortgage payment. Stable environments are conducive to the resolution of stressful situations. Helping our clients to identify the elements of their life which promote stability are essential during a time of crisis.

The sixth element of crisis counseling is challenging irrational beliefs and unrealistic expectations.

We need to help our clients develop realistic expectations. This comes about through a process of patient education, which we talked about on the first element. In recent society, particularly in the late 1990s and early 2000's, throughout religion, business and psychology the pop-cultural fad has seemed to be "name it and claim it" - a philosophy of "I can talk myself into feeling good about myself, even if things are lousy."

However, no matter how often you claim that you are healthy, wealthy and wise, if you have an IQ of 90, if you are HIV positive and you are living on SSI, you are not healthy, wealthy, or wise.

Now, if your lot in life is to be HIV positive, on unemployment or living on disability income, and functioning at a low cognitive level, it would mean that you are not healthy, wealthy, and wise - but it does not mean that you cannot be happy. It does not mean that you cannot contribute or that you are doomed to be unfulfilled, and it does not mean that you do not have wonderful and tremendous things inside to give to others. Helping our clients to create realistic expectations and to dispute irrational beliefs is an important part of crisis counseling.

The seventh element of crisis counseling that we must address is impulsivity.

The cycle of impulsivity is simple: Every time our client feels, they act before they think. They are essentially too "FAT"; every time they Feel, they Act before they Think.

The client in crisis feels a tremendous amount of emotion, and the actions they take without conscientious thought are often automatic and self-defeating, and serve only to reinforce the crisis.

When I tell clients they are too FAT, once they get over the initial offense (because this has nothing to do with their weight) and understand what I mean, I then tell them how to THIN down. They can utilize the FTA THIN diet: Feel THINK Act.

“Fat” and “thin” are words and concepts they can relate to, and using them in this way can help put their thought processes into perspective for them.

Creating interventions that can help our clients alter their firing order and think before they take action can be powerful. Borrowing techniques from impulse disorder treatment strategies - rubber bands on the wrist, mental images of stop signs and so forth, can also be quite useful.

The eighth essential element of crisis counseling is to help our clients develop situational supports.

Situational supports are the people who can help our client return to a pre-crisis level of functioning. Sometimes the only situational supports available to clients are in fact professionals, perhaps even the crisis response team.

However, in the very first contact with our clients, we need to be assessing not only what professionals are in their world, but what people could be, should be, or ought to be in their real world.

I like suicide contracts, but not because they limit a professional’s liability. (And as a matter of fact they may actually increase our liability, because in civil court, if we have a client who succeeded at suicide and we had suicide contract with them, the attorney who is suing could simply say, ‘If you believed they were so suicidal that you needed a contract with him, why would you let him/her out of your office?’)

But, I like suicide contracts or “crisis planning sheets” because they help my client to identify the real people who could be, should be, and ought to be in their world before they enter crisis.

Now, I have seen a lot of professionals complete a suicide contract by putting their own name on there. For example, “I Joe-The-Client agree to call Richard-The-Therapist at 555-1212 if I feel suicidal.” This is not smart.

The reality is, my clients cannot contact me 24 hours a day, 7 days a week. This is not because I am not benevolent, but because I am simply unavailable a lot of the time, especially outside my regular office hours. Sometimes I am working with others, sometimes I am travelling and teaching out of the country, and sometimes I am asleep, so that I will be able to work with others who I have a commitment to the following day.

A therapist cannot be the on-call savior of all his or her clients. When dealing with a suicidal or crisis-oriented client like a histrionic or borderline personality disordered individual, on the contract or crisis-planning form I want them to enter the name of an ‘outside the office’ real person who really can be there for them 24 hours a day, seven days a week.

I may share my number with some clients who seem to be without *any* situational supports, and I may initially suggest '911' or the crisis response hotline, but for most clients, you want them to put down their AA sponsor, or their mother's or neighbor's name, or their clergy person's name - someone from their real world who really can be there for them as an identified situational support.

With clients experiencing crisis, we want to know not only what skills need to be taught to the client, but also who else can help teach them; who can be beneficial to them during a time of crisis. If you have client who appears to have no situational supports, or who perhaps through their own behavior has alienated those who could be most helpful to them, the main task of counseling then becomes helping them to identify and connect with real people, through perhaps twelve-step groups, church groups, neighbors or family.

The ninth element of crisis counseling is acceptance.

The concept of acceptance is vital for our clients to grasp, and one of the most important treatment goals that we can implement in crisis counseling.

Acceptance is far different from liking something or becoming comfortable with something or endorsing something. We can accept things we do not like. In a time of crisis, we can accept that something happened, even if we wish it had not happened. Acceptance simply means recognizing the reality of a situation or event, and moving forward from that point, seeing it for exactly the way it is, perhaps miserable, intolerable, uncomfortable, or even something that is disheartening or devastating. For the clients in our caseload, acceptance is, to quote the Big Book of Alcoholics Anonymous, "The answer to all of our problems, today."

As I said at the beginning, these nine elements of crisis counseling are not the only hallmarks or tasks in the counseling process, but in order for us to be effective - and thus ethical - I think these nine things need to be considered.

Instead of responding strictly to the emotions that clients experience during difficulty, being able to provide the educational services, to recognize what is good despite adversity, to assess stability, to manage impulses and draw upon the strengths of other people are all tools that can help us to be effective with our clients who are in crisis.

MANAGING CRISIS EVENTS: SUICIDE

As we move on now to address some specific crisis events, I want to begin with suicide. In all of the counseling work that we do, working with a suicidal client can be the most difficult that we personally face.

It is often easy for us to become caught up into the extreme depression and chaos that our clients who are suicidal experience, and we may also become frustrated by our client's seemingly stubborn suicidal ideation.

When responding to the emotions of a suicide crisis, it is important for us to both follow an ethical foundation for intervention, and also find tools that can help us to manage our potential liability in treating such clients.

Although this is not a workshop on suicide, I want to discuss briefly the four specific duties we face in caring for a suicidal client. Professionals who fail in these duties can be held to high levels of liability in civil court. Additionally, it is my belief that professionals who fail to fulfill these duties also provide, at best, remedial counseling services.

Our first duty in caring for a suicidal client is to protect them.

Now, this does not mean that we have an obligation to bring our suicidal client home with us, or to follow them around 24 hours a day. It also does not mean that we have an obligation to put ourselves in an unsafe situation. For example, it is not the professional's role to physically disarm a suicidal client who may be threatening suicide in our office. That is what '911' is for. However, we do have a duty to protect our client from themselves, and one way to do this is by helping them find healthy situational supports who can be with them until safety can be assured, such as family, sponsors or community members. Additionally, we can also protect our clients by hospitalizing them or providing other crisis intervention services that may be available within the context of our employment situation's treatment delivery services.

The second duty we have is to perform an accurate assessment.

Probably nowhere in the counseling world is assessment more important than when dealing with a suicidal client. All services available to the suicidal client at the community level are predicated upon the answers to our assessment of two things: lethality and immanency.

The questions we have to ask while assessing suicidal ideation are 1) how soon is this going to occur? (immanency), and 2) if and when a suicide attempt occurs, how lethal will that attempt be? (lethality).

One of my favorite tools is the Adult Suicidal Ideation Questionnaire (ASIQ), which is available through PAR (Psychological Assessment Resources), because it can help assess the validity and immanency of suicidal threats.

I also like using this resource because it helps provide another layer of procedural documentation. "Did you assess for suicidal ideation? Did you check for lethality and immanency?" When you answer yes, and the prosecuting attorney asks for proof, you can hold up the copy of the ASIQ, or other relevant assessment tool.

The third duty we have is to diagnose, and to diagnose correctly.

This means not only a diagnosis of perhaps a mental illness such as bipolar disorder or major depression, but we also have a duty to assess and diagnose our client's response to crisis, and thus to ascertain targeted, effective situational supports.

It is amazing to me how many professionals do not know the specific criteria from the DSM-IV for the diagnosis of Major Depression or Bipolar Disorder, or the rule-outs for other similar conditions. Quite often, professionals will rely on 'instinct' or assumptions - or sadly even the benefits package available to the client - when determining a diagnosis, rather than using professional assessment tools or pulling out the DSM-IV to confirm data after an interview.

If you fail to diagnose correctly, and especially if you fail due to lack of proper assessment protocol, and your client attempts or successfully commits suicide, you will quite likely be in a world of liability hurt.

But perhaps even more importantly, we have an obligation to perform these accurate assessments because it is from them that we are able to develop the interventions most appropriate for our client.

The fourth duty we have is to follow an established protocol.

It is my contention that the mental health community is filled with many different ideas and philosophies about life and living, and that some of these philosophies can sometimes become so important to a mental health professional that they actually obscure the professional's ability to follow an established protocol with clients who are in crisis.

I touched on this a bit in the previous two sections, but let me give you a more detailed example, albeit a rather humorous exaggeration of the failure to follow established protocol.

Let's say that you have a depressed client, and that you are a believer in the power of Feng Shui. You believe that the reason your client is depressed is because they are not Feng Shuiing correctly, and that the reason they are not

Feng Shuiing correctly is because the energy flowing through their dwelling place has not been directed in such a way as to create harmony within the individual's emotional state.

So, based on your belief in Feng Shui, you suggest that the client have a contractor come over and take some walls down, and move their door from one side to another side, so that positive energy can flow throughout the house more readily.

Then, you look at the colors of their walls and the color of their front door, and you make recommendations to change their color scheme to be in a harmonic convergence with your own biases and beliefs about the power of Feng Shui to lift a person's mood.

Now, you may believe that you have helped your client, but unless you follow an established professional care protocol for assisting the suicidal client, you are likely to find yourself in civil court.

With our depressed client who is suicidal, the standard of care is not moving her door from one side to the next; it is assessing immanency and lethality; it is looking at the physical, psychological and social factors contributing their depression, and finding appropriate solutions.

Cognitive-behavioral therapy is a standard of care that has been well documented in our profession, and is certainly appropriate with the suicidal client; Feng Shui is not.

We are allowed to have a variety of different personal beliefs and to bring those beliefs to the counseling setting *as appropriate*. However, we must not let our personal biases or beliefs stand in our way of following the established protocol that our professional community has adopted for the resolution of crisis events.

Furthermore, it is essential that we document how we have provided adequate standards of care.

There are five standards of care that the professional dealing with a suicidal client is required to document.

First, “Are you thinking of killing yourself or other people?”

It is essential when dealing with a suicidal client to also assess for homicidal ideation. There is a fine line between suicidal and homicidal ideation, and in our home study course on suicide intervention and prevention I give a list of indicators that can help the professional to assess whether or not the suicidal person has the potential of becoming lethal towards others as well.

I can't tell you exactly where that line is, but I do know that many people who are suicidal choose to take others out with them, and you should be aware of this as well. Susan Smith is a perfect example of a suicidal person who became homicidal instead. Asking your clients the question and documenting that we have asked them about their thoughts in regards to killing themselves or other people is essential.

The second standard of care to document is, “Have you attempted suicide in the past?”

Clearly, the best indicator for future behavior is past behavior. Anytime we have a client who has attempted suicide in the past, we have a client who is exponentially more likely to attempt suicide in the future than a client with no history of suicide attempts.

The more recent the suicide attempt, the more likely that another suicide attempt will be made in the future. Documenting our assessment over a client's prior suicide attempts provides the information necessary to assess the potential for the lethality.

The third standard of care in our documentation is, “Do you have a plan for suicide or homicide?”

The person with a well-developed plan is, of course, more likely to attempt suicide than those who have no plan. Assessing our client's plan also lets us know the level of lethality.

Often we may work with clients who have vague suicidal thoughts, but no plan. As professionals, we become uncomfortable talking to these individuals about plans, believing that if we talk about this subject it will give clients ideas that they otherwise did not have. I think the contrary is true; if we talk honestly with our clients about suicidal plans, it actually lets them know that they can talk honestly with us about any subject, and that we are willing to listen and provide interventions to them.

The fourth thing to document is that we have asked our clients whether the means are available to complete their plan.

Are weapons easily accessible? Are medications available? Is there a suitable place for the actions that they have contemplated to occur? These things also let us know levels of lethality, and perhaps even the immanency.

The fifth thing that we want to document is that have we assessed who is available for our client to call upon for help.

We cannot be the only person available to our suicidal clients. Our major task in the counseling process with a suicidal client is to find out who else can be available to them during their time of crisis.

We also want to do a little third-party assessment work when compiling the names and numbers of situational supports. In other words, we want to make sure that the client in crisis is listing healthy people in their life as potential contacts, not the corner drug dealer or their abusive ex-husband. Taking a few minutes to ask a few questions about their support suggestions can help eliminate or reduce future exacerbated crises.

The following tip-sheet is titled "PLAID PALS." This comes from the San Francisco Suicide Hotline, which is one of the oldest continuing hotlines serving our country.

The acronym PLAID PALS is designed to help those who are assessing a suicidal client to identify issues related to potential risk.

Having this reference sheet handy can help us to make certain that we complete our required duties and document the important issues for treating the suicidal person.

P.L.A.I.D. P.A.L.S.

Things to watch for when assessing potential suicide risk...

Plan -- Do they have one?

Lethality -- Is it lethal? Can they die?

Availability -- Do they have the means to carry it out?

Illness -- Do they have a mental or physical illness?

Depression -- Chronic or specific incident(s)?

Previous attempts -- How many? How recent?

Alone -- Are they aloneright now? Do they have a support system? A partner?

Loss -- Have they suffered a loss? Death, job, relationship, self esteem?

Substance Abuse (or use)? Drugs, alcohol, medicine? Current, chronic?

When working with clients in crisis - and especially violent or suicidal clients - it is imperative to assess for substance use and abuse.

The use of any mood-altering substances, even in small quantities, exponentially increases the likelihood of suicidal and homicidal action - even at .05 blood alcohol level, which is legal to drive at all 50 states.

The first part of the brain affected by alcohol consumption, even simply a drink or two, is the part that controls reason, judgment, and self-control. This is why a person can dance better (or at least they believe they can dance better) after only one glass of wine or two beers. Even though they are not "drunk," they don't mind looking silly any longer because the part of brain that controls reason, judgment and self-control has been compromised.

A suicidal or high-risk violent client who has consumed even in small quantities of alcohol or other mood-altering substances can suddenly experience the encouragement necessary to do things or follow through with ideas that they otherwise would not do, when not under the influence.

If you follow the news, you may notice that domestic violence cases often spike after big sporting events, when people sit around and drink a lot while watching the game.

POST-CRISIS COUNSELING

Let's move on now to another issue of crisis counseling: post-crisis resolutions. There are many diagnoses that can be given to clients who are recovering from crisis events or who have recently experienced difficulty, but PTSD or post-traumatic stress disorder probably tops the charts. Major depression, adjustment disorder, anxiety diagnoses, and intermittent explosive disorder may also fit our client who has experienced recent crisis.

I want to caution you to be thorough in your assessment and labeling of a post-crisis diagnosis. I have included below the actual diagnostic criteria for post-traumatic stress disorder (PTSD) from the DSM-IV because it is one of the most frequent diagnoses given to our clients who will experience crisis, and, I believe, one of the most frequently mis-assigned.

POST-TRAUMATIC STRESS DISORDER -DIAGNOSTIC CRITERIA - FROM THE DSM-IV

A. The person has been exposed to a traumatic event in which both of the following were present:

- (1)** the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- (2)** the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1)** recurrent and intrusive distressing recollections of the event, including images, thoughts, and/or perceptions. **Note:** In young children, repetitive play may occur in which these or other aspects of the trauma are expressed.
- (2)** recurrent distressing dreams of the event. **Note:** In young children, there may be frightening dreams without recognizable content.
- (3)** acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and/or dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific re-enactment may occur.
- (4)** intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- (5)** physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

- (1)** efforts to avoid thoughts, feelings, and/or conversations associated with the trauma

- (2) efforts to avoid activities, places, and/or people that arouse recollections of the trauma.
- (3) inability to recall an important aspect of the trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect (*e.g.*, inability to have loving feelings)
- (7) sense of a foreshortened future (*e.g.*, does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hyper-vigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one (1) month

F. The disturbance causes clinically significant distress and/or impairment in social, occupational, and/or other important areas of functioning.

- Acute** Duration of symptoms is less than three (3) months
- Chronic** Duration of symptoms is more than three (3) months
- Delayed Onset** Onset of symptoms is at least six (6) months after the incident

The diagnostic criteria for PTSD requires not simply that the person has experienced difficulty or trauma, or has witnessed something devastating, but rather that six specific factors are present.

The first criteria, A, is that they must be exposed to a traumatic event in which both of the following are present: 1) the person has to experience, witness, or be confronted with an event that involved actual death or threatened serious death or injury, and 2) the response of that person must be intense fear, helplessness or horror.

Many people experience difficult and uncomfortable events in life. Suffering from difficulties in life do not yield a diagnosis of post-traumatic stress disorder.

Criteria B requires that the event from Criteria A is *persistently re-experienced*. A valid diagnosis cannot be made unless the client is experiencing the event over and over, in similar situations or 'phantom' type ways.

Criteria C states that the client must attempt, actively and persistently, to avoid the stimuli associated with the trauma, and that they experience a numbing in responsiveness, in three or more ways.

It is perhaps normal following a trauma for people to avoid certain stimuli in a couple of ways for a period of time, but when we see three or more persistent avoidances, the criteria for post traumatic stress disorder begin to be met.

However, not only must Criteria A, B, and C be present, but D, E and F must be present as well.

Criteria D is the persistent symptom of increased arousal indicated by at least two of the following: 1) difficulty falling or staying asleep, 2) irritability or outburst of anger, 3) difficulty concentrating, 4) hyper-vigilance, 5) an exaggerated startle response.

It is important to note that the symptoms of increased arousal we are evaluating must have their emergence following trauma, and not be present before the trauma, or the criteria cannot be used for the diagnosis.

I think the most interesting aspect of the diagnosis of PTSD is that Criteria E requires that the duration of the disturbance is at least one month.

On September 12, 2001, there were a whole lot of people in New York who appeared to meet the criteria of PTSD - but even though the September 11th World Trade Center disaster was tremendously difficult for all of those who witnessed and were there that fateful day, the reality is that the diagnosis of post-traumatic stress disorder could only be given to them when at least one month had elapsed since the time of specific trauma.

The reason why is simple: It is normal, not pathological, for us to experience many of these above-mentioned symptoms immediately following a disaster. It only becomes pathological when the duration is more than one month.

Criteria F for the diagnosis of PTSD is that the disturbance experience has to cause clinically significant distress to our client, and impair them in important social, occupational, or other areas of functioning.

I think post-traumatic stress disorder is a particularly well developed diagnosis, and as such, it concerns me that in the assessment process following crisis, the diagnosis of PTSD is so frequently given - without professionals becoming familiar with the specific diagnostic criteria.

There are many people who experience trauma and may even need help resolving that difficulty, but they may have a psychiatric condition other than PTSD, or no psychiatric condition at all. Sometimes life is simply difficult, and the diagnosis of a psychiatric illness does not apply.

If we make an inaccurate assessment and assign the wrong diagnosis - even in effort to help our client collect third-party reimbursement in the short run - we

may assist them financially, but in the long-run, we do a disservice to our clients, because errant diagnosis leads to faulty, ineffective interventions.

(Not to mention the ethical and legal violations of intentionally misdiagnosing-for-dollars.)

PATIENT EDUCATION IN CRISIS: WORKING WITH CHILDREN

Tremendous amounts of resources are available on our professional association's websites. I want to share with you a wonderful fact sheet that came from the American Counselors Association on helping children handle trauma.

Following September 11th, the ACA was asked to develop a fact sheet that could guide professionals on helping parents, teachers and other caregivers of children to cope. Fortunately, they generalized the fact sheet so that it could be a useful tool for dealing with other types of trauma and difficulty that children may experience, as well.

Crisis Fact Sheet: Helping Children Cope with Trauma

ACA fact sheets may be reprinted with attribution.

After any disaster, children are most afraid that the event will recur, that they or someone they love will be hurt or killed, that they may be separated from those they love and be left alone. Here are ways that you can help children cope with trauma:

- 1) Children under the age of 6 should not be exposed to the TV videotape coverage of the event or similar events, and the viewing time allowed older children should be limited.
- 2) Allow children to express their feelings about what has happened and share your feelings with them. Regressive behavior (i.e., thumb-sucking, night-wakings, and bed wetting) may occur in response to the trauma. Do not punish or scold the child for the behavior, but instead try to help him or her put their feelings into words.
- 3) Reassure children that they are now safe and that they are loved.
- 4) Be honest with children about what has occurred and provide facts about what happened. Children usually know when something is being sugar-coated.
- 5) Try to return yourself, your children, and your family to as normal a routine as possible. This helps provide a sense of security and safety.
- 6) Spend extra time with your child, especially doing something fun or relaxing for both of you.
- 7) Remember the importance of touch. A hug can reassure children that they are loved.
- 8) Review family safety procedures so children will feel prepared the next time an emergency situation occurs.
- 9) Talk with teachers, baby-sitters, daycare providers and others who may be with children so they understand how the child has been affected.

10.) Watch for signs of repetitive play in which children re-enact all or part of the disaster. Although excessive re-enactment of a traumatic experience may be a warning sign, this behavior is an appropriate form of expression of emotions. Encourage a child who is not able to articulate their express their feelings through coloring, drawing, or painting.

11.) Praise and recognize responsible behavior and reassure children that their feelings are normal in response to an abnormal situation.

I find these eleven ideas particularly useful for the professional helping children deal with trauma. We are probably aware of all eleven things, but as professionals we need to recognize that sometimes the parents of the children that we care for are not aware of the importance of these eleven factors. Additionally, teachers and other caregivers who provide services to our clients would likely benefit from having this information.

The first guide says that children under six years old should not be exposed to replay coverage of difficult events. This is because young children are often unable to put things into perspective and to recognize that videotape coverage of a past event is not actually reoccurring. Toddlers and pre-schoolers have a difficult time distinguishing between fantasy and reality, and may believe that elements of the trauma they are witnessing on TV actually put them in real jeopardy. Additionally, older children just do not need to see the same trauma over and over, even if they know that it is not happening again.

The second idea is to help children express their feelings, and for us to model by sharing our feelings with them. Children need to know that it is okay to talk about how they are feeling about what happened, and that it is normal to experience fear, sadness, confusion, and so forth. While they may expect adults to be in control and have the power to 'fix things,' they need to know that adults experience the same emotions they do, and that sometimes some things cannot be fixed.

The third tool is to reassure children following trauma that they are now safe, and that they are loved. This is part of moving forward, and eventually experiencing acceptance. Yes, something happened, but it is over now, they are safe, and there are people who care about them who will protect them and help them to recover.

The fourth idea from the ACA is to be honest with children about what has occurred, and to provide facts about what happened. When we hold back the truth from children, they will know that it is being sugar-coated and they will distrust us. They do not necessarily need all the gory details, but just the basic facts about how or why a situation occurred.

And, if you do not know how or why the trauma happened, it is okay to admit that, because it is the truth - just take care to make sure the child understands that it was not their fault, and that they are not responsible for making it better.

The fifth tool is to try to return children and families to as normal of a routine as possible. Routine provides security and safety, and is an essential tool in helping children to resolve crisis and move forward. Some things may have changed as a

result of the event or situation, but many other things remain the same, and life must move on.

Number six is spending extra time with the child, especially doing something fun or relaxing. It may be difficult for the adults to take a 'time out,' and it may feel disrespectful to intentionally 'have fun' after a devastating or traumatic event, at least at first, but this is essential for the child, and likely beneficial for the adults, too.

The seventh tool is for us to remember the importance of touch. A simple hug or a nonsexual, non-shaming affirming touch that simply says, "I am here," can assure children that they are loved and that they are safe. Reaching out physically can bridge gaps and facilitate healing, even at times when there seem to be no words.

The eighth tool is to create and review family safety procedures so that children can decrease their anxiety by being prepared for the next time an emergency situation occurs. Children are quite imaginative and prone to exaggeration. The trauma they experienced may have been during a car wreck, but if they did not know what to do then, they may develop anxiety about what would they do if there was a house fire. Helping them to feel confident that they have a plan or strategy for handling potential future traumas, even ones completely unrelated to past trauma, can go a long way towards recovery.

Number nine is talking to teachers, babysitters, daycare providers and others who are in the life of a child who has experienced trauma, so they can understand how a child has been affected. It is important that these situational supports know the basics of what has happened, how the child is dealing so far, and specifically how they can be useful to the child to aid in recovery.

Number ten warns us to watch for signs of repetitive play. Re-enactment of the events is often a normal part of a child's trauma-resolution process, but excessive or obsessive re-enactment or discussion might be a warning that the child is unable to express other emotions or move past the event.

The eleventh tool from the ACA is to praise the child and point out their responsible behaviors following a trauma, and to reassure children that their feelings, however difficult to experience or different from their normal "pre-crisis" feelings, are normal now, in response to an abnormal situation.

Tools like these eleven indicators can go a long way toward helping us provide ethical treatment - good therapy - to children on our caseload who may have experienced recent trauma or loss.

ETHICAL DECISION MAKING

The American School Counselor Association has developed an eight-stage model for making ethical decisions that I think is particularly useful in coming to conclusions about what course of action we should take, when responding to the dilemmas unique to crisis counseling.

ETHICAL DECISION-MAKING MODEL From the American School Counselors Association

Steps in Making Ethical Decisions

- 1.) Identify the problem of dilemma
- 2.) Identify competing principles
- 3.) Review relevant ethical guidelines
- 4.) Obtain consultation
- 5.) Consider possible and probable courses of action
- 6.) Consider the consequences of various decisions
- 7.) Decide on what appears to be the best course of action
- 8.) Implement the decision.

Five Moral Principles:

- 1.) Autonomy
- 2.) Beneficence
- 3.) Non-maleficence
- 4.) Justness
- 5.) Fidelity

We have dilemmas because we know that something about a situation is “wrong,” and we must first determine what that specific something is.

The second step is for us to identify the competing principles. This means to decide if it is an ethical, legal, or a moral dilemma. This must be done, because your response will be different based on what kind of dilemma it is.

Determining WHY the situation is wrong helps us to determine the flavor of dilemma, and thus what we should do about it.

Morality can be seen as the collection of beliefs as to what constitutes a good life (i.e. The Golden Rule, accepted cultural or religious values, etc).

Legality pertains, of course, to the law, official judicial rules and regulations.

Ethics are the standards that govern the conduct of a person, especially a member of a profession - which is why most professions have a written Code of Ethics or professional conduct to follow

Some situations may present dilemmas on multiple or all levels. For example, having sex with a client is A) ethically wrong, and B) legally wrong - however, depending upon your personal moral standpoint, it may not be C) morally wrong. (We strongly hope this is not the case!)

But the point is that some dilemmas are easy to identify as ‘ethical’, and others can be more tricky to sort out.

Dilemmas with a ‘legal’ status generally present clear resolutions: report the crime to the appropriate authorities. This is your ethical (and perhaps moral) responsibility.

Moral dilemmas are not always the same as ethical ones. For example, some may see it as an invasion of privacy (immoral) to make surprise home visits to your clients, but this is not unethical if it is part of your job description (which, one would assume, would follow all legal protocols).

The third step is reviewing the relevant ethical guidelines. Our professional association’s Code of Ethics can often provide us with the answers to the problem that we have identified in number one.

If after reviewing the relevant ethical guidelines we find we are in a dilemma where the answers are still unclear, the fourth step indicates that the ethical counselor has a responsibility to obtain consultation with their colleagues or supervisors about possible solutions and interventions.

The fifth stage is to consider the possible and probable course of action you should take, based on reviewing the relevant guidelines and obtaining consultation. Outlining the strategy on paper is often helpful.

Number six is to consider the potential consequences of the various decisions that we might make. Simply because there may be consequences does not mean that you do not have to follow through with implementing a resolution. Instead, it means that you will need to plan how to handle or make arrangements to handle the fall-out, once the actions have been taken.

The seventh step is probably the second most difficult aspect of crisis intervention in ethical decision making, and that is to review your outline of potential response and now decide on what appears to be the best course of action. This can be difficult because sometimes in ethical dilemmas there appears to be no good solutions, or no resolutions that are favorable to us as a caregiver.

Sometimes we need to recognize that in dealing with ethical dilemmas, we are, in fact, caught between a rock and a hard place; what appears to be the best course of action may not be the *ideal* course of action. But then, ideally, the situation would not have occurred in the first place.

But the most difficult step is often number eight - actually implementing the decision, knowing that we will be held responsible for the choices we make.

Being able to step back from the emotion of the scenarios that we face during a time of crisis, and recognizing which step we are at in the problem-solving process can go a long way toward helping a professional to develop intervention strategies that are not only useful to the clients on our caseload, but also to manage the liabilities that we potentially face.

Every step in the Ethical Decision-Making Model is predicated on five moral principles: autonomy, beneficence, non-maleficence, justness, and fidelity.

We want our interventions to promote patient autonomy; this is especially true for the suicidal individual. Beneficence means not doing harm to our client. Non-maleficence has to do with creating interventions that truly benefit our client. Justness means that we will provide services to our clients who are in crisis, despite our own biases. Sometimes clients are in crisis through their own actions, but we have an obligation to provide just services to them, regardless of how we perceive their situations. The fifth moral principle of fidelity means that we will be faithful to our clients in executing our responsibility, from the moment that we accept them as a caregiver until they are successfully restored to a pre-crisis level of functioning, or appropriate referrals to ensure their safety during a time of crisis can be made.

I hope this information has been useful to you. My goal through this CEU course has been to outline some of the major tasks in crisis counseling that are of concern from an ethical perspective, and to outline a foundation of essential responsibilities professionals should focus on, in order to make certain that quality care is provided to clients during crisis situations.

THANK YOU FOR YOUR PARTICIPATION IN THIS COURSE

To receive continuing education credit for this course, you must have read this entire text file - and your respective professional association's Code of Ethics.

You must also complete and return the Evaluation of Learning Quiz and pay the CEU fee. (Instructions are on the next page.)



We always appreciate constructive input from our customers - even when it's 'negative', so please feel free to fill in the "Additional Comments" section of the Grade This Course evaluation when you submit your quiz and payment.

Richard K. Nongard, LMFT, CCH, CPFT
Executive Director

"#10 Ethics: Crisis Management, Assessment and Decision Making"

3 Continuing Education Clock Hours

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EVALUATION OF LEARNING QUIZ - PAGE 1 of 4

PRINT & FAX or MAIL THIS PAGE AND THE ANSWERS PAGES TO OUR OFFICE

*** * * * OR * * * ***

You may complete and submit this information **ONLINE** by following this link:

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#10 Ethics: Crisis Management - Assessment & Decision Making

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EVALUATION OF LEARNING PAGE 2 of 4

“Ethics #10: Crisis Management - Assessment and Decision Making”

3 Hours of Approved Continuing Education Credit

The purpose of the following Evaluation of Learning questions is to:

- A.) Verify that you have read the required course materials
- B.) Demonstrate an understanding of the practical application of the course materials
- C.) Officially document your participation and completion of this course

➔ ANSWER THESE 20 T/F EVALUATION OF LEARNING QUESTIONS

- T F 1. I have read the entire required .pdf text file for this course.
- T F 2. I have read my respective Professional Association’s Code of Ethics.
- T F 3. From a liability perspective, it is important to note that whether we are a dues paying member or not of our respective professional association, in civil court we will be held to our professional association’s ethical standards.
- T F 4. In order for us to be effective in helping clients resolve crisis situations, the first thing that we often need to do is provide basic education and teach specific skills.
- T F 5. During a time of crisis, anger can be an energizer and a motivator that helps a person get tasks done, even when those tasks are perhaps so overwhelming that they otherwise would not have the ability to do them.
- T F 6. Helping our clients to create realistic expectations and to dispute irrational beliefs is not important in crisis counseling because when the crisis is over, they will think clearly again.
- T F 7. Richard tells his clients that they are too THIN and need to become more FAT in their thinking processes.
- T F 8. A good therapist is always the on-call savior of all his or her clients.
- T F 9. All services available to the suicidal client at the community level are predicated upon the answers to our assessment of two things: lethality and immanency.
- T F 10. The person with a well-developed plan is more likely to attempt suicide than those who have no plan.
- T F 11. The acronym PLAID PALS is designed to help those who are assessing a suicidal client to identify issues related to potential risk.
- T F 12. When working with clients in crisis - and especially violent or suicidal clients - it is imperative to assess for substance use and abuse.

CONTINUED →

EVALUATION OF LEARNING (CONTINUED) PAGE 3 of 4

Course Title: "Ethics #10: Crisis Management - Assessment and Decision Making"

- T F 13. Many people experience difficult and uncomfortable events in life. Suffering from difficulties in life do not yield a diagnosis of post-traumatic stress disorder.
- T F 14. For the diagnosis of PTSD, the disturbance experience has to cause clinically significant distress to our client, and impair them in important social, occupational, or other areas of functioning.
- T F 15. The fourth tool from the ACA's fact sheet is to praise the child and point out their responsible behaviors following a trauma, and to reassure children that their feelings, however difficult to experience or different from their normal "pre-crisis" feelings, are normal now, in response to an abnormal situation.
- T F 16. Ethics are the standards that govern the conduct of a person, especially a member of a profession.
- T F 17. Our professional association's Code of Ethics can often provide us with the answers to the problem that we have identified.
- T F 18. Every step in the Ethical Decision-Making Model is predicated on these five moral principles: braveness, cleanness, courteousness, kindness and reverence.
- T F 19. Sometimes clients are in crisis through their own actions, but we have an obligation to provide just services to them, regardless of how we perceive their situations.
- T F 20. Cognitive-behavioral therapy is a standard of care that has been well documented in our profession, and is certainly appropriate with the suicidal client; Feng Shui is not.

GRADE THIS ONLINE COURSE! – Page 4

*It is helpful to us if you return this form via snail mail or fax,
along with your Quiz and Payment. Thank-you!*

Participant Assessment of Home Study CEU Course

#10 Ethics: Crisis Management, Assessment and Decision Making

3 Credit Hours

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