Dan's Talking Points Memo Ch. 1

Wilcoxon, Remley, and Gladding; Chapter 1 (v5.3.1)
For discussion on August 29, 2019

Values as Context for Therapy

A word on words. You will notice that I use the term *patient* when referring to those with whom we work. Do I like this term better than *client*? Actually, I prefer *client*, as it implies a cooperative, interactive relationship rather than a medical one. Even our textbook abhors the use of the word *patient* as Kelly (1955) states, the term *patient* "implies someone who sits patiently, waiting for something to happen or something to be done to him or her." That's passive. Our treatment is dynamic.

I use the term as a matter of law. Our profession is one of very few to enjoy the legal protection of *privilege*, or the mandate to decline testimony in a court proceeding to protect information learned from or about someone in treatment. Only a written waiver of privilege or a court order can compel me to reveal to anyone. As written in law, we have "psychotherapist-patient privilege." Nowhere in law is it written, "psychotherapist-client privilege" or "counselor-client privilege."

1. Note the fulcrum on page 3; it shows how one's internal factors (within the fulcrum, e.g., values, morals, courage of your convictions, etc.) balance the external factors encountered in the practice of psychotherapy. What do you think?

2. What's wrong with the question (p. 3), "Why not just learn the rules and their nuances then act as we are supposed to act?" We could save ourselves the trouble of this course if that could happen …

3. Interesting scenario on the handicapped-parking dilemma, page 3. You've been there before yourself and YOU made a decision. Outline the process of the decision that you made. Be honest!

4. I like the comment on page 4 regarding those who willfully neglect obligations for mandatory actions as psychotherapists. The author suggests "avoiding detection" may be their overriding objective, with no higher goal.

5. Think about the assertion by Bergin (1985, p. 5) that "even trying to avoid a particular value choice by being noncommittal amounts to taking a value position." Discuss.

6. Understand the statement by Welfel (1998, p. 5), that "as long as one distinguishes between desirable and undesirable change, one is invoking values."

7. Note Baruth and Manning (2003, p. 5) described culture as "institutions, communications, values, religions, genders, sexual orientations, disabilities, thinking, artistic expressions, and social and interpersonal relationships."

8. The authors (Wilcoxon, Remley, & Gladding, 2012, p. 6) correctly noted that "gender-based differences are significant factors in the perspectives and values brought to the therapy process by both patient and therapist." Give some examples of how males and females see the world differently … or do they?

9. I'm sure that no one would disagree that ethnic/racial heritage is a major factor in the development of, as well as expression of values brought to therapy by patients and therapists.

10. Note how social class distinction and socioeconomic status are perceived as "power or powerlessness, risk or security, and privilege or helplessness" within a values orientation (p. 7).

11. The authors note that sexual orientation (and all iterations within, i.e., gay, lesbian, bisexual, transgender, and questioning) may affect the interactive nature of therapy, hence reflect value priorities. By the way, now are we doing with sexual orientation differences in society? Things getting better? Worse?

12. While surely affecting the treatment process by way of stereotyping or other value-typing notions, disability (of therapist and/or patient) can affect treatment process and outcomes. Tell me more.

13. "Religion" is a major value orientation and has been the root of "misunderstanding" since the beginning of time; if you think about it, haven't most wars had a religious origin? What about the crusades? And middle-eastern tension? *Oy vey!* How do we move beyond these issues in our psychotherapy practice when working with folks who may not share our religious values?

14. Have you noticed that when talking about "spirituality," which also holds a strong value component, folks don't get so defensive? What's up with that?

15. Many of the beliefs that we hold near-and-dear (or can't seem to relinquish) result from "introjects" (a Gestalt Therapy term) that came from our family of origin prior to the time we were cognitively able to evaluate and synthesize value-laden material. Frankly, I suspect MOST of our cultural, racial, and gender values come from introjected material.

16. FYI, the book uses the word "worldview" to describe the "overriding cognitive frame of reference that influences most of [one's] perceptions and values" (Baruth & Manning, 2003, p. 8).

17. Note the figure on page 9 that looks like a nuclear reaction, or whatever. It is the author's rendition of how all of the above factors of values come together to create one's "core values." Take a look at it and get the pix.

18. Note how the authors make the case that our "worldview" serves as a stabilizing element when we deal with external forces in our lives. Further they equate this concept to homeostasis, which is, of course, a major precept in systemic family therapy (p. 11).

19. The authors emphasize "value-sensitive care" as a cornerstone of effective psychotherapeutic treatment. Notice the relevance of knowing your own values and having a solid self-understanding as a requisite factor in providing value-sensitive care.

20. This is an interesting place for the authors to pose the question, "Is psychotherapy an art or a science?" (p.14). I contend that it is a mix of both. The knowledge base of your COUN program addresses the "science" part, and the values and attitudes you bring to the implementation of the science is the "art" part. What do you think?

21. It is important to relate "value-sensitive care" to questions such as, "Do you pathologize your patients based on diagnosis (values on depression, bipolar, borderline, etc.)?" "Do you have any automatic prejudices when meeting with a dysfunctional family?" "Do you form any judgments about your new patient when the initial phone contact reveals he or she is dealing with GLBTQQ issues?" "When you learn that your referral comes from CPS and the woman you are about to see has been separated from her infant because of abuse issues?" Get honest here!

22. Take a good look at CASE 2 – Tim. What about that possible barter arrangement with the Native American artist?

23. The context of care is interesting because your patients will present "within a context." The "context" is the relevant backdrop to the presenting problem, which says to me that one can't merely look at the problem alone, but most view the "problem" within the "context." **Problem:** Bob lost his job. **Context:** He is 60 years old, undereducated, the economy is bad, he has a family with kids that need insurance, he is depressed and anxious, he and his wife are fighting because she, too, is scared. A therapist who is "problem focused" and not "context aware," is a fool in my book …

24. The authors emphasize our being "grounded in professionalism" as an enhancement to patient growth. Lots of folks have gone before us and have established models of effectiveness, and many have gone before us who have done damage. Professionals know the difference between effective and damaging behaviors, and part of this course is to help you know the difference.

25. Understand Napier and Whitaker (1978, p. 17) as they delineate the "Battle for Structure" (which must be won by the therapist) and the "Battle for Initiative" (which must be won by the patient). This concept runs throughout the text.

26. What does Dell (1983, p. 18) imply by stating, "objectivity is impossible"?

27. Since therapists and patients can't possibly share a total value set, doesn't it make sense that therapy goals be developed collaboratively? Their insights and new awareness, along with my promotion of new and realistic patient skills, could make for a dynamic set of treatment goals!

28. Something I have always marveled at is summarized by Efran and Lukens (1985, p. 22), when they state, "Families don't start changing at the therapist's office. They are always changing and the visit to the therapist's office is simply the next step in their process." So true. Our role is to facilitate change that primarily occurs outside our office. In the scheme of things, we have very little time with our patient families, which makes it very important that our treatment is powerful and effective.