



Scenarios for Study and Discussion

Scenario One

Fred W. is a professional counselor who provides some services for an Employee Assistance Program on an outpatient basis. He receives an urgent call from the intake coordinator at one of the EAPs for which he provides services, asking if he can have an immediate session with an employee from one of the client companies of the EAP. The employee is a teller at a bank at which a robbery has occurred, and she has been very much shaken up by the incident. The robber came to her window and showed her a gun inside his coat, demanding all the money at her window and telling her she was going to get shot if she made any attempt to halt the robbery or tell any of the other people in the bank. This was the employee's first week on the job, and even though she had been trained in how to handle a robbery, she was having a hard time calming herself down after the incident. Because none of the other employees in the bank even knew that the robbery was occurring, no one else was affected by the incident in any immediate way. Fred is asked to meet the employee and is given the choice of meeting with the employee at the bank alone or with other employees present, or in his office with either the employee and her manager, or just the employee. How should Fred approach the decision about how to structure the meeting with the employee and how should he approach addressing the trauma with the bank employee?

Scenario Two

Erin G. is a hospital social worker working at the veterans Administration. She has recently started to see Gerald M, a 44-year-old man coming into treatment with a history of headaches, insomnia, gastrointestinal discomfort, and persistent worry and anxiety severe enough to be affecting his work and family life. During the first session, Gerald reported that he had sustained a broken jaw and hip, as well as a compound fracture of the left leg, in a traffic accident in Iraq 7 years earlier. In the accident, he had been pinned against the steering wheel in severe pain and worried about being exposed to potential enemy fire while the rescue team used the jaws of life to pull him free. The smell of gasoline after the accident contributed his worries for his safety, and he is having a difficult time filling up his gas tank because the smell of gasoline triggers flashbacks at the service station. He was evaluated by a staff psychiatrist, treated with anxiolytic medication and referred for counseling. When relaying to Erin the series of events that led to his being traumatized, he reported that during the time he had been trapped, he had felt disconnected from the surrounding events, almost like being outside his own body, and ended up losing control of his bowels in the pain and the worry. Shortly after his period of physical rehabilitation, Gerald started to experience a number of difficulties. He became excessively worried about germs and odors, and began to wash himself to the point of leaving cracks in the skin of his fingers, and would avoid garbage cans when he encountered them in public. He became increasingly anxious and self-conscious in public, and began to drink too much in order to "calm his nerves", although he entered into AA and was able to achieve sobriety. The patient has a good deal of cognitive clarity about the connection between his accident and his symptoms, but seems unable to stop himself from avoiding the triggers. Most embarrassingly, he tells Erin that he has been unable to control his urge to spend almost 20 minutes cleaning himself after a bowel movement.

Scenario Three

Janet is a single, 35-year-old Caucasian female with a history of anxiety and intrusive worries about her physical attractiveness. She grew up with a very dominating mother who was obsessed with physical appearance, modeling and inculcating in her children an extremely strong linkage between one's outward presentation to the world and one's worth, and combining this with serious corporal punishment if her children would not obey her or challenge her in any way. While Janet understands cognitively that she is a relatively good-looking person, at a very deep level she cannot help but scrutinize her appearance, looking for any signs of fault or imperfection. As a result, she is self-conscious to the point of paralysis, leading to a somewhat severe withdrawal from social

interactions. This avoidance of facing her worries about her appearance has magnified the problem, leading to a self-propagating cycle of withdrawal, increased anxiety, and increased focus on imperfections related to her appearance. She has attempted several courses of psychotherapy, but neither CBT nor psychodynamically driven therapy seem to be able to break the cycle of her withdrawal-anxiety-preoccupation. She has begun to give up hope on the process of controlling her anxiety, and lately in her therapy sessions she has been spending the last fifteen minutes of each session looking at the time with increasingly growing anxiety.

Scenario Four

James P. is a thirty-nine-year-old white male who presents in recovery from multi-substance abuse, and with a history of serious depression, low self-esteem and self-worth, and a serious binge eating disorder. He has very few friends and has not been able to maintain any romantic relationships, spending a lot of time alone. He reports that he grew up the youngest child in a very abusive family, with a distant ineffective father and a non-nurturing mother with serious psychological difficulties, as well as two older siblings who bullied, humiliated and controlled him virtually all of his childhood. From a very early age, he was overweight and a compulsive eater, reporting that he was the subject of a great deal of teasing at school. He was not allowed to engage in any after school activities when growing up, as his mother forced him to perform menial janitorial work at a local parochial school to make extra money for the family. When client came into his teenage years, he discovered some real talent as an athlete, and become a star on his high school football teams, getting in touch with stored reserves of anger that fueled his very aggressive play. Client also reports getting in a number of fights during his high school years, enjoying the release from this but reporting that his anger scared him as well. He reports that the only two states he seemed to be capable of were complete surrender/submission or explosive anger. Although his sports abilities provided a sense of status, client reports he was unable to receive much pleasure from it, as he always had the feeling of being a fake or phony and still remained extremely unhappy. Nevertheless, he was able to leverage his sports success and good grades into a scholarship to a good college away from home. During his freshman year at college, he developed serious problems with social anxiety, accompanied by an acute sense of depersonalization and a collapse of any sense of self-confidence. During this period, he first began to abuse alcohol, then got heavily into club drugs and cocaine. Client had one semi-serious suicide attempt during this time, which he never told his family about. After college, client was able to be accepted into a prestigious graduate program, during which time he began to attend 12-step programs and was able to stop using alcohol and drugs. However, with the cessation of drug use, client began to have increasing difficulties controlling his binge eating, and his weight began to increase steadily except for a couple of occasions when he forced himself to adhere to a strict diet. A difficult career transition precipitated a major drop in client's sense of identity and a final crisis of confidence, at which point his binge eating began to spiral completely out of control, at which point he entered counseling. A thorough assessment process revealed the presence of a fairly serious attachment disorder, dysthymia, anhedonia, significant self-loathing, extreme hopelessness and pessimism, and very poor skills at relationships and interpersonal effectiveness. Client presented with enormous difficulties in sorting out his affective life, as all of his emotional responses to his childhood problems felt like a great mass of undifferentiated feelings that had nowhere to go. Additionally, client has serious distortions in how much weight he has gained and what his body looks like.

Scenario Five

Paula M. is a mental health clinician who has just moved to a very rural area in GA. To her knowledge, she is the only mental health clinician within a 50-mile radius. Paula just received her license at the independent level six months prior to this move. Her specialty area is general case work with children. She is receiving ongoing supervision from one of her more experienced colleagues from her previous job, for which she is paying out of pocket. Two days after settling into her new practice, she receives a call from a potential new client, Roberta S. In the call to request services, Roberta reveals that she is in the midst of a difficult pregnancy and is worried about committing to face to face treatment every week. However, she and her husband, Ray, are on the verge of a separation. She has wanted to engage in marital counseling but could not find any counselor that was accessible - until Roberta came to town. She would like to work with someone who could provide face to face counseling

when it is possible for her to travel and telemental counseling if she is not at a good place to travel. Paula explains that she does not have any significant experience in marital work. Roberta says that she is willing to accept that Paula is not a specialist, but Paula has to be better than no one, and there is no other recourse for her marriage.

Scenario Six

Helen G. is a licensed clinician who works at an eating disorders and addiction program as part of a large, multi-hospital healthcare system. Services include inpatient, partial hospitalization and intensive outpatient treatment. She has an extensive background in working with substance addicted patients, but has been asked to expand her role to include work with the treatment team for eating disorders. To help with her transition to this new arena, she has been provided with supervision from a nationally known eating disorders specialist in New York. Due to the severe shortage of clinicians who work with eating disorders in more rural parts of her state, the healthcare system is moving into the provision of telemental health services to expand the reach of treatment and provide some additional treatment options. Helen has already completed a twelve-hour course as part of her preparation for future use of this treatment model. Helen has been contacted by a potential new client, Veronica M., 17, who has been struggling with anorexia nervosa for the past year and a half. Veronica works as a trainer at a local gym and after an arduous day of work, she would find it hard to have the energy to travel from one side of the city to the other in order to attend her counseling sessions.

Scenario Seven

Abe P. is a clinical social worker who specializes in working with couples around sex and intimacy concerns. He has just been contacted for TMH by a new couple. The pre-screening call reveals the following information. Julia L. is an attorney who prosecutes rapists and people who perpetuate violence against women and considers herself a feminist and a strong advocate for women's rights. She is married to Kenneth, a calm, kind and gentle man who directs a drug and alcohol treatment center. He has a history of prior relationships with what he describes as "strong women", but also with two men briefly in his early twenties. Married for 11 years with 2 children, Julie and Kenneth have been experiencing problems with sexual intimacy and a flagging sex life. While they love each other and their emotional intimacy is great, they have lost their sexual spark and it is beginning to take a toll on their relationship in other ways. The precipitant for coming to treatment was an argument and its resultant interactions. The couple had had a loud and nasty disagreement in a cab on the way home from dinner and drinks. Both parties were fairly intoxicated. Once home the argument escalated until Kenneth suddenly grabbed Julia and kissed her hard, pushing her roughly onto the bed and peeling off her clothes. To her surprise, Julia enjoyed the interaction and felt strangely aroused by Kenneth's assertiveness. The next day they each had extremely mixed feelings. Even though they were both shocked that their argument had devolved into angry and aggressive sex, they were also both glad that their sexual dry spell had shifted and were more than slightly disturbed and confused that it was the hottest sex they had ever had. Julia expressed some dismay and shame with her enjoyment of being in a more passive sexual position and felt incredibly uncomfortable with her seeming arousal from being dominated. Kenneth felt similarly confused and was equally dismayed with himself for enjoying dominating and controlling Julia sexually. Each was shaken, with Julia wondering how she could be a feminist and fight for women's rights during the day and enjoy the prospect of being dominated at night. Kenneth faced an equivalent crisis over his personal identity when this new side of himself emerged. While they were a little bit happy that they had more exciting sex, both parties wanted help to sort out their discomfort, and noted that they wanted to explore their new approach to sex again – only this time sober.