Published in final edited form as:

Am J Fam Ther. 2014 October 1; 42(5): 413–425. doi:10.1080/01926187.2014.909657.

Strategies for Managing Difficult Clinical Situations in Between Sessions

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Abstract

Therapists often have to deal with situations that make them uneasy to leave their clients on their own. They can go home and wonder what their clients are doing, whether they are safe, have a place to stay, even whether or not they are fighting. These thoughts can be overwhelming for the therapist. They may think about their clients' safety, they may also be worried about their own professional way of dealing with these situations, and its implications for them as clinician. The aim of this paper is to assist therapists to manage their own anxiety and to help them help their clients in between sessions in difficult situations such as suicidality, child abuse and neglect, intimate partner violence, crisis and stress management.

Keywords

Suicidality; child abuse and neglect; intimate partner violence; crisis management and stress management

Introduction

As therapists, we often have to deal with situations that are difficult in nature such as suicidal ideation, child abuse, and intimate partner violence. These situations are far too real for many therapists working in the field and can become overwhelming. Sometimes, such events in our client's life can be described as crises, as they represent a turning point in a person's life and seem insurmountably hazardous to them to the point that they are left paralyzed and unable to react (Roberts, 2000). People in crisis often will be unable to change or lower the impact of stressful events with common coping methods, feels increased confusion, tension or fear, be highly uncomfortable, and quickly rises to a state of personal disequilibrium (Roberts, 2000). It is important for mental health professionals to intervene in such situations and put their clients in the best possible position to overcome their current

Note: The case examples in this article including names have been changed to protect the privacy of those in the situations described.

problems. Crisis intervention refers to a “therapist entering into the life situation of an individual or family to alleviate the impact of a crisis to help mobilize the resources of those directly affected” (Roberts, 2000, p. 9). Crisis intervention, includes: “planning and conducting a crisis assessment, establishing rapport and rapidly establishing a relationship, identifying major problems, dealing with feelings and emotions, and generating agreement” (Robert, 1991, p. 16).

There are a number of options for those who can turn to for immediate assistance in times of crisis such as calling 911 and 24-hour hotlines. These crisis intervention programs aim to intervene at the earliest stage of crisis possible and are great tools for mental health professionals to refer their clients for crisis management that may arise in between sessions. Despite the availability of these support systems, therapists often have to deal with difficult situations. In between sessions, the therapist may be worried about their clients’ safety and well-being. These situations pose significant challenges to the therapist in appropriately handling the issues. In the following sections, we discuss how therapists can help their clients in between sessions to alleviate these difficult situations.

Suicidality

Suicidal ideation is one of the most common forms of crisis in therapy sessions that causes many clinicians great anxiety during and between sessions (McGlothlin, Rainey, and Kindsvatter, 2005). Therefore, it is important for clinicians to have a greater understanding of risk factors for suicide and knowledge on how to deal with concern for clients between sessions (Sharry, Darmody, and Madden, 2002). Risk factors for suicidal ideation or an attempt vary for each case. Researchers have identified that higher scores on the Beck Depression Inventory (BDI), higher frequency of domestic violence, previous attempts of suicide, substance abuse, poor economic situation, lack of close relationships, and a hopeless future orientation may be risk factors of suicidal ideation or a suicide attempt (Hintikka, Viinamaki, Koivumaa-Honkanen, Saarinen, Tanskanen, and Lehtonen, 1998). These identified risk factors do not indicate that their presence will cause a client to attempt suicide, but they should be taken into consideration.

When a client reports suicidal ideation to their clinician, the first step in the session is to conduct a suicide assessment. A suicide assessment includes examining the client’s plan, intent, means, prior attempts, and substance abuse (McGlothlin, Rainey, Kindsvatter, 2005). The suicide assessment will allow the clinician to consider what can be done to make sure the client is safe between sessions. Social and family support are some of the most important factors known to reduce the risk of suicide (Hintikka, et al., 1998). To take advantage of these support systems, many clinicians work with the client to complete a no-harm agreement. The no-harm agreement may be oral or written between the client and therapist. It is an agreement stating that the client will not harm or kill themselves and call someone in their support system or emergency personnel before taking their life (Page and King, 2008). There is evidence that the no-harm agreements benefit the client and the clinician by facilitating increased commitment to positive action by the client, strengthening the therapeutic alliance, lessening anxiety, aiding in the assessment of suicide risk, and providing a means of documenting what was done to care for the client’s safety (Page and

King, 2008). The clinician must also be careful to consider that a no-harm agreement may provide the client with possible means of support, but be aware that a no-harm agreement does not completely reduce the risk of a suicide attempt (Page and King, 2008).

No-harm agreements are important, but must be used alongside other in-session interventions to prepare the client for time between sessions. The clinician may also highlight the client's coping skills, examine their support system, explore reasons for living, and envision a more hopeful and optimistic future (Sharry, Darmody, and Madden, 2002). These tasks that occur in session may help prepare a client to deal with suicidal ideation between sessions, and reduce the clinician's anxiety knowing that there is support for the client between sessions.

Suicidality Case Example

Janet was a 45 year old Caucasian female who began treatment at the community based clinic with the report of depression. The clinician also learned that the client had been diagnosed with depression by a psychiatrist about 10 years ago and took medication for about a year. Explaining she was not happy with the side effects, the client stated she discontinued medication and no longer had contact with a mental health professional. After discontinuing her medication, she attempted suicide for the first time and returned to the hospital several more times during the past couple years for suicide attempts.

Due to the client's history of suicide attempts, diagnosis of depression, and current report of suicidal ideation, the clinician decided a suicide assessment was necessary. The clinician asked further about past suicide attempts, the client's current intent and plan, and any sources of social or family support. The client stated she currently did not have a plan to harm herself, but continues to think of suicide often. The clinician then spent time with the client creating a no-harm agreement in order to identify potential sources of support and any other emergency or community resources the client could use between sessions. The client stated she would contact those in her support system or emergency personnel if she was considering suicide, as well as follow up with the referral from the clinician to speak with her medical doctor.

Child Abuse and Neglect

Child abuse and neglect require helping professions, including MFTs to break bounds of confidentiality when reasonable suspicion of child abuse or neglect are present. Researchers and commentators have discussed the challenges, implications, procedures, and best practices of child abuse reporting (Besharov & Laumann, 1996; Flaherty et al., 2008; Jones et al., 2008). An overarching goal of the course of therapy with a family where child abuse or neglect is present is to remove these behaviors and preserve the safety and wellbeing of children and families. At present, the established pattern for therapists to assist families between sessions to keep children safe is the mandated reporting protocol arranged by state. A variation of child protective services is then dispatched to investigate, assess, and intervene in order to protect the child. Some therapists may fear that their relationship with clients may be damaged or that initiating involvement of child protective services will create division or problems in the family.

Research has been conducted with physicians, who were originally the only helpers mandated to report abuse (Besharov & Laumann, 1996), to understand what factors played a role in their decision of whether or not to report suspected abuse. Jones et al. (2008) interviewed 434 pediatric primary clinicians in search of factors influencing decisions around child abuse reporting behavior. Among other themes, one strong influence on whether or not a report was made was the knowledge of the family, or familiarity with them. Other factors influencing the decision included perceptions of the outcome of reporting, case history, and the family's utilization of available resources. Flaherty et al. (2008) further investigated the child abuse reporting behavior of clinicians and identified that certain aspects of a potential abuse situation were related to a higher likelihood of report. Overall, these clinicians did not report all of the suspicious injuries they came across, even if they were highly likely to be due to abuse. Factors including unfamiliarity with the family, race, and the type of injury seem to play an important part in the decision making process around reporting. As family therapists, while it may not be true in all cases, a fair amount of familiarity may be expected to be present at the time a concern about child abuse or neglect presents itself.

Besharov and Laumann (1996) argue that under-reporting or failure to notice or properly intervene in the presence of abuse may have left children who were in harm's way without help. Of equal concern has been inappropriate reporting, or making reports where the intervention of a child protective agency was not warranted. Since the time that mandated reporting laws have spread to other professions beside medicine, a large number of child abuse cases were still unreported, but also a number of "unsubstantiated" claims were made which created unnecessary strain on investigative bodies and families (Besharov & Laumann, 1996, p. 40).

Supervision may be one of the most important resources in supporting family therapists in navigating the delicacies of recognizing and reporting suspected child abuse or neglect while maintaining a positive working relationship with clients. Supervisors can aid clinicians in choosing questions to ask families to determine a reasonable suspicion of abuse while not being compelled to be investigators of the case.

Child Abuse and Neglect Case Example

Clear communication between all mandated reporters who may have contact with a given family is necessary to ensure that appropriate reporting measures are being taken. One such multi-layered setting is a hospital. The therapist worked as a family therapist intern in a children's hospital while in training and saw a number of families sometimes just once and others for years while their children underwent medical treatment. Callie, age 3, was in the middle of treatment for a disease that would require at least 36 months of treatment. She lived with both parents and had a younger sister who was less than a year old. The medical staff was all familiar with Callie's family by the time the therapist began working with them. At one appointment, Callie's mother reported an accident to the medical doctor which left a conspicuous burn on Callie. The therapist met with the family later and they also told me about the incident. Later that day, the therapist spoke with one of the nursing staff who had some concern that the injury may not have been accidental and was considering reporting

the incident. Together, she and the therapist reported the injury to the state protective agency that day.

What the therapist did not know was that the medical doctor in charge of Callie's treatment had assured the family that no report would be made regarding the incident. The therapist had assumed that given the nurse's concern that all medical staff would corroborate the report and felt similarly. The report and subsequent investigation caused the family to elect to cease receiving family therapy at the hospital as they were surprised and felt betrayed by the report. The therapist facilitated conversation with the medical doctor and other staff to discuss what happened, how the reporting decision was made and which communication channels were not consulted. Most chiefly the therapist gained a much deeper understanding of two important things. First, there is a need for clear communication with families when a report will be made about them unless communicating that would increase risk for the child. Secondly, the therapist learned a great deal about talking openly with other professionals who are working with clients to understand their impressions and to report collaboratively when possible.

Intimate Partner Violence

Intimate Partner violence is another common form of crisis that can arise in and between couple's therapy sessions. It has been defined as "the patterned and repeated use of coercive and controlling behavior to limit, direct, and shape a partner's thoughts, feelings, and actions" (Almedia and Durkin 1999, p.313). Clients who present with family violence issues bring challenges along with a great deal of anxiety for family therapists. These challenging issues may include client safety, court-referred clients, and mandated reporting (Murray, 1996).

While dealing with families with violence, it is important to have violence prevention strategies in place. One major prevention strategy involves the clinician identifying the abusers and victims in the family, and discussing situations in which violence may be prompted along with what can be done to avoid or work against such situations. The therapist also identifies the risk factors for further violence, including any triggers such as substance use or situational issues that may prompt such behavior. A non-violence contract signed by both partners is useful for the therapist to establish that such behavior would be inappropriate (Murray, 1996). Some therapists also keep daily contact with clients to monitor the build-up of tension that could lead to violence.

Therapists can also teach clients different techniques that they can use at home when they feel that a situation may be escalating out of control. These techniques can include time-out procedures so clients know how to walk away from a situation that is getting hostile by recognizing cues that lead to trouble. Therapists can discuss with clients what to do in times of crisis such as leaving the house, going for a walk, and calling the police if things get too out of hand. Things such as anger control and problem-solving techniques can be taught to clients so they can do such things on their own as well during hard times (Harris, 1986). If clients find themselves in worst case scenarios, it is important to have a safety plan. The safety plan can include making sure all weapons are out of the house and that the partners

have a place to go if they feel unsafe at home. Therapists can meet with clients individually for pre and post-session safety assessment to make sure they feel safe going home with their partner. If not, the therapist will encourage the two to separate to avoid any violent situations (Duncan, 2011).

There are proponents for and against having partners that perpetrate domestic violence upon one another seek counseling services together. Those that are against the partners being seen together fear that the victim may be placed in a position of physical or emotional danger due to the fact that they may disclose something that warrants retaliation from their partner after the session. Ultimately it is the therapists' responsibility to make sure their clients are safe and if they fear violence will be perpetrated within the couple, it may be best to separate the two parties. On the contrary, there are also therapists who believe that there are couples that can be seen together and worked with to end domestic violence by using a well thought out, careful screening process. There are standards that therapists can set when working with couples suffering from relational violence, including the following: 1) partners are fearful of one another or fearful that what they say in the session could later come back to hurt them, 2) the two partners have different stories about the history of violence in the relationship, 3) there is substance use or weapons in the home, and 4) both partners are not committed to maintaining the relationship. (Duncan, 2011). Victims of domestic violence do not always want their relationship to end and by helping them to work through their problems to have the violence stop, they can empower themselves from being victimized and maintain their relationship (Duncan, 2011).

Intimate Partner Violence Case Example

Gerald and Maggie were in their late twenties. They had been married for 6 years. They had four children together. Maggie was a stay home mom. Their presenting problem was based on a recent crisis situation. They were returning from a family vacation. While driving on the highway, Gerald made a dangerous move; consequently Maggie started screaming. Gerald slapped Maggie. They came to an emergency session.

After the first session, in order to develop a deeper understanding of the issue, the therapist tried to imagine herself in Maggie's position and wrote all the possible feelings that she would experience if something like that happened to the therapist. The therapist tried to identify the associated feelings, such as the shock that he is doing something like that, the concern that he may continue to doing it, and the fear for her children in the case the marriage comes to an end if he will continue, the feeling of hurt, the shame that something like that is happening to her, and the anger about how dare he would do something like to her. Identifying Maggie's feelings and sharing them with Gerald created an open communication. Gerald was surprised to hear that just a slapping can cause these intense emotions. He indicated that he did not know how his behavior made Maggie feel. He said he did not think it was a big deal, it was just a slap. Following a suggested intervention to prevent violence in the relationship, the therapist asked Gerald to sign a detailed no violence contract. In this detailed contract, he also wrote down Maggie's feelings and how his slapping affected her, potentially their children and marriage. He wanted to show Maggie

that he is not going to do something like that ever again by signing this detailed no violence contract.

General Crisis Management

While the crises dealing directly with legally recognized issues, like child abuse, and suicidality/homicide are frequently discussed in clinical trainings and literature; other family crises are not always frequently addressed. Other possible crises include the following: disclosure of infidelity, a chronic health diagnosis, crises related to homelessness and poverty. In these instances therapists often scramble for ways to handle the issues appropriately.

Preparation and education are arguably the most useful tools in crucial moments of family crisis. Conceptualizing crises within the family context and process allows a therapist to not be debilitated by content of an unexpected therapeutic event. A firm systemic grasp on the homeostatic nature of family events and the feedback mechanisms within them provides a reframe of crises that ensures a map for the therapist on how to proceed (Bobeles, 1987; Everstine and Everstine, 1983). Case consultation after crisis-involved sessions is often very useful. Presentation of varying perspectives and sharing one's own plan of action provides a thorough consideration of the best strategies to utilize. Having an accessible consultation team within proximity at all times allows security and accountability, and acknowledges one's willingness to not rely on their own judgments.

General Crisis Management Case Example

The therapist saw the client Dave for approximately one year in a community health center. Dave was morbidly obese, had a host of medical problems including chronic pain, an absent and uninvolved family, and at the time had very little income (approx. \$650 a month in disability). Dave was in need of expensive medications for pain and had thus decided to apply for VA benefits to be able to acquire all he needed. The therapist received a call shortly after Dave had applied through the VA and he was in panic. His acceptance for medical services through the VA had cut his food stamp allotment, had discontinued his Medicaid health insurance, and had decreased his monthly income by \$200. Dave was in crisis and was inconsolably angry, which later turned into hopelessness and desperation. He felt he would be evicted, would die from not being able to get his medication, and would be unable to have enough food to make it. The therapist found herself wanting to "save" Dave in any way she could, even if it was not therapeutic, just to provide relief.

Dave came to the office for a therapy session the following day and after speaking to him, it was evident there were some options for the therapist to act as an advocate for Dave. The therapist spoke with a representative at the disability payments office and a representative at the VA. She was also able to connect Dave with some resources for food and medication assistance. The more the therapist did to help Dave at that moment, the more he was able to calm down and understand what changes would be occurring and why. Simultaneously, the more the therapist saw that Dave was calmer, the more she internally felt peace as well. Within a month, Dave had his food stamps back, had medications at the VA, and was soon receiving a \$1000 increase in his disability income with a supplemental veterans' pension.

Stress Management in Mental Health

Stress is an inevitable phenomenon in which no person is exempt. Lazarus (1966) explains stress as someone's relationship between themselves and the indefinite factors embedded within the environment. Continuous appraisals of our surroundings and the availability of coping mechanisms determine our levels of stress and ultimately our ability to manage stress. High levels of self-esteem, good social support, emotional stability, and exercise are factors that aid in an individuals' resilience to stress (Edwards, Hannigan, Fothergill, and Burnard, 2002).

Therapists are not free from experiencing symptoms of stress, and often carry residual "side effects" when seeing clients if stressors are not managed appropriately. These emotional strains are related to large number of case loads, dysfunctional working environment, lack of resources, and increased administrative involvement (Edwards et al., 2002; Onyett, Pillinger, and Muijen, 1997; Prosser, Johnson, Kuipers, Dunn, Szmukler, and Reid, 1997). Commonly reported coping techniques of stress include thought suppression, complaining, rationalization of situations, peer support, management support, thinking positively, problem solving techniques (Gibb, Cameron, Hamilton, Murphy and Naji, 2010), time management, clinical supervision, and supervision with colleagues (Reid, Johnson, Morant, Kuipers, Szmukler, and Bebbington, 1999).

Growing bodies of supportive literature endorse stress management practices through the use of mindfulness (Walsh and Shapiro, 2006). Walsh and Shapiro (2006) communicates effective elements in achieving buffering characteristics through the mental health professional's incorporation of routine exercise, nutrition and health, interaction with nature, relationships, and the utilization of relaxation and stress management. Another helpful mechanism for stress management is clinical supervision. Seeking support can sensibly share the weight of immediate stress (Reid et al, 2009). Peer and colleague support has also been found as an effective aid in alleviating symptoms of stress (Gibb et al., 2010).

Stress Management in Mental Health Case Example

Twenty-year-old Gina had experienced a black out of her memory while driving to work. Terry, Gina's mother, suspected she was using drugs causing her black out. As we explored other alternative explanations (i.e. medication side effects, fatigue, etc.) in family counseling, Terry appeared to grow more agitated. The therapist made the decision to visit with the mother and daughter individually. Following individual time, Gina informed the therapist she was ready to share with her mother the fears of an upcoming operation and requested feedback from her mother. Terry's reaction was unexpected, denying any alternative explanation of the black out, and that Gina would be evicted from their home that day. After failed mediation, Terry had escalated in to a scream towards her daughter and continued to do so until the therapist dismissed her. Safety plans and procedures were followed prior to session terminated. The therapist had less than 10 minutes to manage the stress of the previous session before she met with her next client. The therapist utilized her time by practicing deep breathing techniques, acknowledging the sources of stress. The therapist affirmed, "There was nothing more you could do for them at the moment. You

encouraged them to call. You did a safety plan. Ultimately it is their life and you are not in control of that.” With one last body scan, the therapist had managed her stress.

Discussion

As therapists, when we are dealing with difficult situations, there are multiple layers of information we need to take into account during conceptualizing and creating our treatment plans such as the severity of the issues, access to resources, support systems of the families, gender and culture issues. We also are in need to be conscious about our ethical and legal obligations. The American Association of Marriage and Family Therapists (AAMFT) provide a code of ethics that clinicians must follow to make sure clients are protected. The first principle of AAMFT code of ethics is a responsibility to clients, which states that “marriage and family therapists advance the welfare of families and individuals.” This is a reminder that the safety of the client experiencing suicidal ideation, child abuse and neglect, intimate partner violence, crisis in general is of great importance. The clinician must be diligent in their efforts to ensure treatment is ethical and to the client’s benefit, and there is an effort to make sure the client is safe between sessions. The second principle in the code of ethics is confidentiality, and each client’s confidentiality must be respected and guarded. Within the second principle, the clinician must share information if required by law, such as a client’s serious intent to attempt suicide, child abuse, neglect and homicidal ideation. For example, for suicidal clients, the clinician would conduct a suicide assessment during session, and determine the client’s intent to attempt suicide. Based on this assessment and the clinician’s responsibility to clients, the clinician may contact emergency personnel or an inpatient facility to further assist the client. The client’s safety must be of high importance to the clinician, and connecting with other resources may be what protects the client between sessions. In domestic violence cases the therapists might have to break confidentiality if suspicion of harming self or others occurs. For the clients who come to therapy under court order, the clinicians would need to have written authorization to release client information. To ensuring client’s safety, the therapists should need to have proper training in case management, safety management, and have knowledge of other resources that maybe helpful for the clients.

Ethical considerations in crisis management require acknowledgement and guidance from the code of ethics governing one’s clinical practice. For the less severe crises how to proceed ethically is not always clear cut and obvious. These ambiguities require decisions based on therapists’ best judgments. To complicate matters further, these judgments often have to manifest in a moments notice when unexpected events and crises occur in session. Without awareness and knowledge of how best to handle these events a therapist is at risk of creating further stress, however it is the therapist’s duty to “do no harm” and thus should be handled cautiously.

Marriage and Family Therapists carry a level of responsibility to their clients, even outside of the scheduled therapy sessions. Therapists hold a professional obligation to educate clients of the possible outcomes of their decisions. With that, clients ultimately have the power to make their own decisions provided the possible risk of their actions.

Another layer of complexity that we need to be keeping in mind while working with cases with difficult situations is the self of the therapist. It is of utmost importance that therapists maintain their own reactions and personal triggers that might arise from client crises. A natural dynamic of crises is the unexpected way that it occurs, often times creating a flood of emotion or personal feelings of chaos, for both therapists and clients alike. The call for the therapist, despite their personal reactions, to maintain and manage the crisis in heat of the moment is a tall order and sometimes extremely difficult. Doing one's own self-of-the-therapist work provides protection from potential harmful reactions in the midst of the unforeseen client crisis. Similarly, it is essential to keep in mind that what might be a crisis from the therapist's perspective and to their life might not be a crisis according to the client and their experiences. Awareness of class and cultural differences in identifying crises is paramount, so as to not impose one's own beliefs and norms on the client. It is possible that there will be times that therapist will be worrying about doing the right thing or will be unsure about whether they properly advise their clients. For these situations, talking to a supervisor will be beneficial, as well as reaching out for expert opinion. Having professional conversations with licensed and senior professionals who had previous experience (keeping in mind about the confidentiality) will help in building clinical judgment. Also, identifying resources to go to at the time of a crisis situation will make the therapist feel more prepared in crisis situations.

In conclusion, therapists utilize variety of skills to intervene effectively to the challenging situations. When applied by a competent therapist all therapeutic approaches are effective as long as they create a supportive relationship with their clients. While working with difficult situations it is also crucial to work with client's strengths and hidden resilience (Ungar, 2010) as well as therapist need to be aware of their own needs or unresolved personal conflicts. In this article, we wanted to raise some awareness on the difficult situations while working with clients and common problems, techniques and interventions to apply to these difficult situations as well as some ethical concerns that we need to keep in mind while practicing.

Acknowledgments

This publication was made possible by the Clinical and Translational Science Collaborative of Cleveland, UL1TR000439 from the National Center for Advancing Translational Sciences (NCATS) component of the National Institutes of Health and NIH roadmap for Medical Research. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NIH.

References

- American Association for Marriage And Family Therapy. AAMFT Code of Ethics. 2006
- Besharov DJ, Laumann L. Child abuse reporting. *Social Science and Modern Society*, May/June. 1996:40–46.
- 3. Bobele M. Therapeutic interventions in life-threatening situations. *Journal of Marital and Family Therapy*. 1987; 13:225–239.
- Duncan E. Domestic violence focused couple therapy. Is it a safe option? *Psyccritiques*. 2011; 54:44.
- Edwards D, Hannigan B, Fothergill A, Burnard B. Stress management for mental health professionals: A review of effective techniques. *Stress and Health*. 2002; 18:203–215.
- Everstine, DS.; Everstine, L. *People in crisis: Strategic therapeutic interventions*. New York: Brunner/Mazel; 1983.

- Flaherty E, Sege R, Griffith J, Price L, Wasserman R, Slora E, Dhepyasuwan N, Harris D, Norton D, Angelilli M, Abney D, Binns H. From suspicion of physical child abuse to reporting: Primary care clinician decision-making. *Pediatrics*. 2008; 122:611–619. [PubMed: 18676507]
- Gibb J, Cameron IM, Hamilton R, Murphy E, Naji S. Mental health nurses' and allied health professionals' perceptions of the role of the occupational health service in the management of work-related stress: how do they self-care? *Journal of Psychiatric and Mental Health Nursing*. 2010; 17:838–845.
- Harris J. Counseling violent couples using Walker's model. *Psychotherapy*. 1986; 23:613–621.
- Hintikka J, Viinamäki H, Koivumäki-Honkanen H, Saarinen P, Tanskanen A, Lehtonen J. Risk factors for suicidal ideation in psychiatric patients. *Social Psychiatry Epidemiology*. 1998; 33:235–240.
- Jones R, Flaherty E, Binns H, Price L, Slora E, Abney D, Harris D, Christoffel K, Sege R. Clinicians' description of factors influencing their reporting of suspected child abuse: Report of the child abuse reporting experience study research group. *Pediatrics*. 2008; 122:259–266. [PubMed: 18676541]
- Lazarus, RS. *Psychological Stress and the Coping Process*. New York: McGraw Hill; 1966.
- McGlothlin J, Rainey S, Kindsvatter A. Suicidal clients and supervisees: A model for considering supervisor roles. *Counselor Education and Supervision*. 2005; 45:135–146.
- Murray CE. Controversy, constraints, and context: Understanding family violence through family systems theory. *The Family Journal: Counseling and Therapy for Couples and Families*. 2006; 14:234–239.
- Onyett S, Pillinger T, Mujen M. Job satisfaction and burnout among members of community mental health teams. *Journal of Mental Health*. 1997; 6:55–66.
- Page S, King M. No-suicide agreements: Current practices and opinions in a Canadian urban health region. *The Canadian Journal of Psychiatry*. 2008; 53(3):169–176.
- Prosser D, Johnson S, Kuipers E, Dunn G, Szmukler G, Reid Y. Mental health, 'burnout', and job satisfaction in a longitudinal study of mental health staff. *Social Psychiatry and Psychiatric Epidemiology*. 1997; 34:295–300. [PubMed: 10422482]
- Reid Y, Johnson S, Morant N, Kuipers E, Szmukler G, Bebbington P. Improving support for mental health staff: a qualitative study. *Social Psychiatry and Psychiatric Epidemiology*. 1999; 34:309–315. [PubMed: 10422484]
- Roberts, AR. *Conceptualizing crisis theory and the crisis intervention model*. Englewood Cliffs, NJ: Prentice-Hall; 1991.
20. Roberts, AR., editor. *Crisis intervention handbook: Assessment, treatment and research*. New York: Oxford University Press; 2000.
- Sharry J, Darmody M, Madden B. A solution-focused approach to working with clients who are suicidal. *British Journal of Guidance and Counseling*. 2002; 30(4):383–399.
- Ungar, M. *Counseling in challenging contexts: Working with individuals and families across clinical and community settings*. Belmont, CA: Brooks/Cole; 2011.
- Walsh R, Shapiro S. The meeting of meditative disciplines and western psychology: A mutually enriching dialogue. *American Psychologist*. 2006; 61:227–239. [PubMed: 16594839]