

The Support Relationship: Developing Quality Support Relationships That Promote Wellness

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Document two in a four part series describing
Helping relationships that promote well being

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Introduction: Learning to Help Others on Their Path to Wellness

Walking the path to wellness is not the same as finding a cure for disease, although healing may be a part of the process. Wellness is a journey of discovering balance, wholeness, and relationship harmony in our lives. Wellness is linked to our perceptions of illness, which is more than disease, and includes those things that prevent/enhance balance, wholeness, and relationship harmony. In some manner, we are all on a journey of wellness and, during this wellness journey, we encounter people who help us and people who hinder us. This text offers descriptions of relationships that help people with their journey toward wellness through processing experiences that occur within the compassion space.

Whether professionally in the role of human service practitioner, providing peer support, or providing family support, we may be asked to help someone on his or her journey of discovering wellness. This help happens within the compassion space. What is presented herein is not a collection of techniques, but rather a general set of guidelines to be used while applying any technique that fits the person's needs. The guidelines presented describe the basic components of the wellness journey and the basic elements of the helping relationship that is used while providing assistance in this journey. There are four components of the wellness journey: discovering wellness possibilities, finding healthy ways of seeking wellness, enhancing wellness duration, and, promoting the types of relationships needed to support wellness duration. When using the helping relationship to assist with these four wellness components there are two helping approaches that need to be balanced with each other: 1) assisting with remembering wellness remembering, and, 2) offering the opportunity of experiencing wellness. Throughout this text this author will refer to these six parts (the four components of the wellness journey and the two helping approaches) as the six

foundational components of the helping relationship. The six foundational components of the helping relationship serve as overarching concepts guiding both practitioner intent and practitioner development while learning to apply the guidelines presented.

The Six Foundational Components of the Helping Relationship

The four components of wellness:

accepting possibility, healthy seeking,
expanding duration, and finding support.

The two approaches for teaching these four components:

education and experience.

The journey starts with the awareness of wellness possibility. Many people, both practitioners and consumers, are not aware that wellness and the compassion space are obtainable. Becoming aware of the possibility and exploring issues around this awareness is the initial step in the discovery of a personal wellness path. As indicated above, there are two approaches a practitioner can use to assist with developing the awareness of wellness possibility: 1) providing information about the possibility, and, 2) providing an experience that illustrates the possibility. Providing information about wellness possibility can be assisted through the sharing of healing stories, through a careful examination of personally-remembered wellness, or through an introspective look at the mindset, or attitude, that inhibits the possibility from being accepted. In addition to teaching information, the practitioner can provide the opportunity for wellness to be experienced. This would be a shared experience that clearly illustrates the possibility of wellness. Such an experience can only happen if the conditions for the “healing relationship” are properly

established. When these conditions are established, then both practitioner and consumer can experience an experiential shift in perception accompanied by a sense of wellness. Once this perceptual shift has been experienced, it serves as the reflective point of wellness possibility -- a part of the individual's personal experience that can be used for remembered wellness. From this point forward the person can begin to seek his/her own path to wellness.

The journey involves seeking the experience of wellness. Once wellness is accepted as a possibility, then the consumer can search for his/her own definition of "wellness" and a new healthy style of seeking wellness. There are two approaches used when helping someone who is seeking wellness: 1) providing information on what others have said about seeking, while also personally reflecting, or 2) providing opportunities for additional wellness experiences that more clearly illuminate the path as part of the seeking process. Information can be provided to the individual about the path others have taken, about relapse, and about habits and techniques. Seeking is a deeply personal process and there are no techniques, rituals, medications, or platitudes that can be universally applied to all. It is more about finding the right pairing of teacher and student, and using the right technique for that pairing at that moment. The seeker can learn to document and reflect upon how they engage in seeking while on their wellness journey. This is an educational process that requires healthy introspection, a process that often needs to be taught. Some of this introspection into one's patterns of seeking can be taught through information, but some of it can also be learned through shared experiences with the practitioner.

A skilled practitioner can offer the opportunity to practice seeking wellness as an experiential process. This journey of seeking "wellness" has many paths. The skilled practitioner learns to walk the path with the other, acting as a guide, reflecting on the journey without interference. The role of support persons for the person learning about seeking wellness is linked to an understanding of the individual's quest for wellness, of understanding how they seek, and

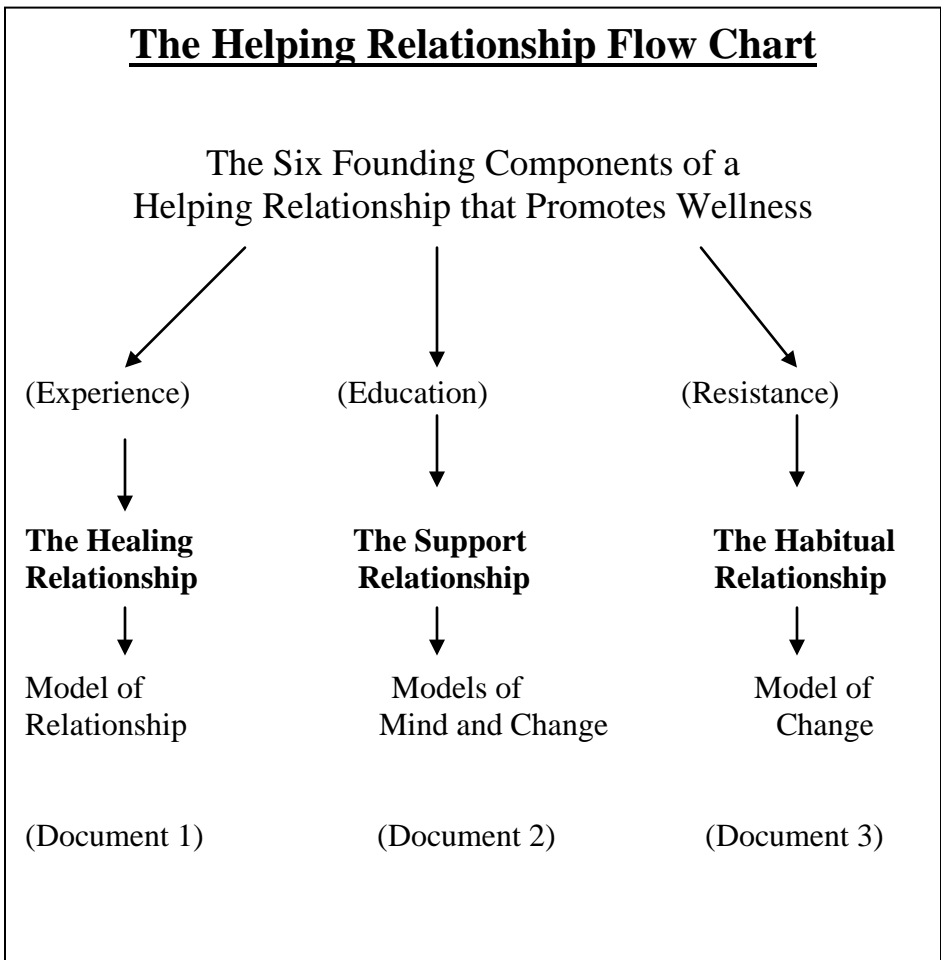
then assisting with his/her natural process of improving his/her personal seeking process. It is not so much a question of a given technique, but rather of finding the right approach for that individual within the mindset of seeking wellness.

The journey shifts to enhancing wellness duration. Once wellness has been experienced as a possibility, and healthy wellness-seeking avenues have been established, then one can experience wellness with increased duration. As with the other components of the wellness journey, there are two approaches to helping someone who is looking to enhance wellness duration: 1) provide information about the wellness duration that can then be a part of personal reflection, or, 2) provide opportunities for wellness experiences with extended duration. Once healthy seeking has been established as a part of the person's way of life, then the person may experience moments in his/her life where the sense of wellness has greater duration. Many different situations in life can contribute to increased wellness duration. Initially, the person may not recognize this. They will need help in clarifying that such improvement is occurring. It is important that the individual find ways to constructively reflect upon these moments of increased wellness duration. There are hundreds of techniques that can help with this process (e.g., journaling, group discussion). Knowledge about one's personal experience can contribute to wellness duration as an important part of the wellness journey. In addition to education, information and reflection, it is also possible that the skilled practitioner can offer to the person the possibility of experiencing expanded wellness duration. This process of facilitated wellness duration is quite difficult. These difficulties are linked to the training of the practitioner and the expectations of the participant. Perhaps the most important point to emphasize is that the journey of wellness must involve increasing the duration of wellness moments in one's life, and that this can be facilitated through both an educational and an experiential process.

Community support is essential for wellness duration. The community needs to provide the individual with the overall systemic

and personal support needed to develop wellness duration. It is important for the consumer to feel supported in their struggle to maintain, or expand, his/her experience of wellness. Within the helping relationship one can provide information about the nature of healthy support relationships, ones that facilitate wellness duration. Relationship support for wellness includes people at work, peers, family, and both health or education paraprofessional and professional staff. This relationship support involves three types of relationships: the healing relationship, the support relationship, and the habitual relationship. These are shown in Figure One.

Figure One:



Training can be provided that describes each of these relationships and how they fit with helping a person on their wellness journey. It is possible for practitioners to offer opportunities where

Community support requires that those people who are to provide the support for wellness duration also should have support. The environment, the language used, the work culture, should all reflect the approach of promoting wellness duration. In addition, systemic factors (e.g., curricula of training programs, and design of progress documentation) need to be re-designed to assist people in their wellness journey.

It is hard to shift from the mindset of matching cure to disease, of being the “fixer”, to the approach of guide on a wellness journey. This “fix-it” mindset is very much a part of how we seek and deliver health care services in this country. The skilled helper learns that diagnosis and treatment are useful, but also that treatment success is enhanced through the healing relationship. The skilled practitioner of the healing relationship does not try to “fix”, but rather offers to take the journey with the person toward well being, and for a short while, offer the opportunity to discover wellness.

Helping people to experience wellness involves 1) accepting wellness as a possibility, 2) developing healthy ways of seeking wellness, 3) enhancing wellness duration, and 4) developing the types of relationships needed to support wellness duration. Helping a person with each of these four components of the wellness journey involves a balance of education and experiential processes. These are the six founding components of the helping relationship that promote wellness. Training in these six foundational components includes understanding the characteristics of the healing relationship, how to access educational information, and how to implement educational information. In addition, one needs to have knowledge of the three types of relationships encountered during the process of wellness support: the healing relationship, support relationship, and the

habitual relationship. The first “rule”, or basic assumption, of

R.1: The Rule of Offering a Helping Relationship

When a helping relationship is offered so also is offered the opportunity to share the compassion space and engage in the healing, the support, and the habitual relationships.

providing a quality support relationship is that when a human service provider offers help to another, s/he is also offering the opportunity to engage in the healing, the support and the habitual relationships. These three relationships are described within three documents each entitled accordingly.

The information needed for presenting a helping relationship that promotes wellness is contained within three documents. These three documents present different aspects of the helping relationship with an emphasis on describing general guiding principles rather than specific techniques.

Document one, “The Healing Relationship”, describes the healing relationship. Document two, “The Support Relationship”, describes the support relationship. Document three, “The Habitual Relationship”, will describe the habitual relationship and barriers that inhibit wellness. The information included herein is based on decades of research, including Ph.D. research at Syracuse University and many years of practicing the healing relationship. The information also includes personal reflections by this author (and other practitioners and participants) on the process of offering help that heals.

The focus of these three documents is not to provide a set of methods or techniques, but rather to provide a set of guidelines for learning to use the helping relationship. The techniques, rituals, methods, explanations, that would be used to help another vary depending on the training of the practitioner, the culture, the situation presented and the expectations of the person seeking help. The practitioner, in every helping possibility, is always entering into a relationship with the person seeking help and the techniques that could be used are dependent upon that unique relationship. The goal of these documents is to clarify the fundamental aspects of that special relationship that fosters another's development of wellness.

Understanding the fundamental aspects of helping relationships that promote wellness will include understanding the different types of relationships encountered by practitioners (healing, support, habitual) so that practitioners can begin to improve their own helping relationships. As the practitioner becomes deeply familiar with the rules and guidelines presented herein, s/he will have a flexible, and eclectic, set of principles to use when providing help to another. This flexible set of principles will assist the practitioner when s/he is attempting to find the best helping approach for the person's needs. It is a set of guidelines that can be used with almost any set of techniques or rituals the practitioner prefers to use within his/her healing practice.

Any person who is asked by another person to help them toward wellness and/or to help him/her cope with suffering can use the information contained within this text. This includes the following:

- Family members, peers and co-workers.
- Paraprofessionals: support staff, aides, and direct care workers.
- Professional staff: counselors, therapists, teachers, nurses, clinicians, social workers, case managers,

practitioners of alternative medicine, pastoral counselors, and psychologists.

The various guidelines contained herein are presented so that a broad audience can understand them. In places where the text presents difficult concepts examples are provided and the basic components of every important concept are highlighted. In addition, for those who wish to pursue more detailed information, a reference list is provided.

This text on the support relationship begins by introducing the reader to the premise that human service practitioners bring to support relationships certain ideas and concepts that shape these relationships. These ideas influencing the support relationship have been grouped under the three models of mind, change and relationship. Following this introduction the document is divided into three sections. Section one presents guidelines for readers seeking to develop a model of mind that can be used in offering quality support relationship. Section two presents guidelines for readers seeking to develop a model of change. Each of these two sections is divided into chapters and the focus of these chapters is not to present a list of techniques, but rather to present rules and principles that govern the application of technique within the support relationship. The final, and third, section presents information to help readers develop their model of relationship. This third section merges an overview of material presented in “The Healing Relationship” (document one) with the material presented here.

Introduction to Developing Quality Support Relationships

When one person asks another for help they enter into the helping relationship. Any human service practitioner, family member, co-worker, or peer who is asked to help a person on their wellness journey is faced with the opportunity to offer the healing relationship and the opportunity to provide a healthy support relationship. “The

Healing Relationship” provides the reader with a description of the healing relationship. This document provides the reader with the basic rules and principles governing the development of a quality support relationship.

The two relationships (healing versus support) have different characteristics and knowing these differences allows the practitioner to offer the type of helping relationship that best fits the situation. The characteristics of the healing relationship have been defined and it is important to reiterate that the healing relationship is associated with a shift in perception and a facilitated sharing of the experience of well being. The support relationship is not used for experiencing this dramatic shift into well being, but rather to provide a healthy environment within which the experiences of wellness can be understood, reflected upon, and integrated into one’s way of being. It is within the support relationship that both the duration and the frequency of well being can be examined and improved. Both of these relationships, the support relationship and the healing relationship, work hand-in-hand to help a person on their wellness journey. It is the practitioner’s skills with these two relationships that enable the practitioner to offer help that heals.

There are many ways that the support relationship can be used. Herein it is described in tandem with the healing relationship for the following applications:

- **Well being information:** Providing information about the possibility of experiencing well being through sharing of the compassion space.
- **Well being follow-up:** Helping a person to interpret and integrate a well being experience, including information on extending duration and frequency.
- **Understanding the walls:** Helping the person to understand the barriers and habits (including working

through dysfunctional patterns) preventing the person from either directly experiencing well being, or expanding its frequency and duration.

- **Sitting in suffering:** Providing a safe and supportive environment where the person can share suffering and gain the strength to sit within their suffering.
- **Support to supporters:** Providing daily support service to others who often “run out of energy”, they get drained, and sometimes “burnt out” – an important role within the support relationship is to help the helpers back to their previous state of well being. Pass on the compassion space.

The main purpose of the support relationship is to support another in their development of well being and their understanding of the compassion space. If a practitioner does not have any personal knowledge of facilitated well being within the compassion space then s/he will need to use some form of the support relationship, instead of the healing relationship, in order to provide help that has a chance of being useful. There are problems in trying to build a quality support relationship without the knowledge of facilitated well being from within the compassion space.

First, the practitioner can not offer the possibility of directly experiencing well being if the practitioner can not facilitate that experience, or know where the person in need could go to get that experience. Second, without knowledge of facilitated well being the support relationship lacks a person-centered direction toward wellness within the therapeutic relationship. Third, knowing about facilitated well being is more about becoming the healer than just practicing techniques. The absence of this healer knowledge risks inappropriate technique application, along with limited practitioner development. The risk of entering into the habitual relationship (described in another book) more often than a quality support relationship is likely

to increase without the balance provided by the healing relationship. The more we know about facilitating well being, the more we can provide quality support to people in their pursuit of wellness. These two relationships (healing and support) work in tandem to provide a helping relationship that promotes wellness.

The support relationship is one part of the helping relationship that promotes well being. The support relationship comes into existence when one person is seeking help and another is willing to provide help. This is the rule of beginning a support relationship.

R.2: The Rule of Beginning a Support Relationship

The support relationship begins when one person asks for help, while another person is willing and able to provide the specific help needed, and the healing relationship is not possible at that moment. In addition the habitual relationship is not present at that moment.

There are human service relationship interactions, which are designated as helping relationships that do not fit with the above rule of support. There are many human service practitioners who are part of a social service system designed to ensure public safety (e.g., prisons and the court system). Within this system people may not come of their own free will to ask for help. Instead they may be brought, or ordered, to get help. The nature of this type of helping relationship can involve considerable resistance. This is resistance that can come from the unwilling participant and sometimes from the practitioner. The resistant, or habitual, relationship is discussed in more detail within another document. There is always an interface between offering the healing relationship, or the support relationship, and working with the habitual relationship. Even with the most resistant people the offering always exists, but the start of the support relationship doesn't begin until the above rule is satisfied.

In addition to resistance inhibiting the beginning of the support relationship, there are times when there is a poor match between the needs of the individual seeking help and the person put in the position of providing that help. Sometimes the help that is requested is beyond the skill level of the practitioner. Examples of this are: 1) a person, or student practitioner, presents with a problem that triggers apparently unavoidable, and non-therapeutic, reactions from the practitioner, and 2) a person presents problems with which the practitioner has no familiarity and 3) when student practitioner encounters a trainer not able to fit the training to the student's needs. The support relationship cannot begin if the practitioner is not capable of providing the support so it matches the individual's needs.

The support relationship is about supporting a person in their development of well being. Without proper relationship support it is very difficult to hold on to the experience of well being one discovers within the healing relationship. Most people do not know how to live a life that is full of moments of wellness. They are too easily drawn into the perception of suffering, by both circumstance and situation. The person who experiences well being and then returns to living with an abusive relative. The man who comes for help, feels a shift toward well being, and then returns to a life of drug use. The woman who frequently experiences anxiety and sometimes terror and for a moment had a shift into well being, but can't quiet her thoughts to rekindle that moment. They all require a healthy support relationship to help them learn how to live in a state of wellness.

The central purpose of the quality support relationship is to foster the continued development of well being through nurturing, guidance and education. This is needed precisely because every one gets "lost", that is they lose sight of what one needs to live in a state of well being. They lose sight of how to live with the inevitable occurrence of suffering. The quality support relationship is designed to help the person get back to what they already know so they can more frequently live in a state of well being.

What Happens When We Decide to Help Another?

We may not be fully aware of it, but when we decide to help another we do so with a set of ideas about what it means to provide help to another person. We enter into the helping relationship with some idea of what it means to provide help to another person. In understanding the nature of a quality support relationship it is important to understand that when we enter into a helping relationship we bring with us our preconceptions about helping. These helping preconceptions are based upon three “models” (sets of rules, ideas, and assumptions) that we carry in our own minds. These three models direct how we will act within the support relationship. These three models are as follows:

- 1) The model of mind.
- 2) The model of change.
- 3) The model of relationship.

In this book, the use of these three models in the helping relationship will be explored. Guidelines will be presented in an effort to enhance the development of quality support relationships. Parts of the third model – model of relationship - are presented in all three ebooks (“The Healing Relationship”, “The Support Relationship” and “The Habitual Relationship”). These three models are presented in an effort to stimulate thought and discussion around the types of models the practitioner in training uses within the support relationships. Being aware of the models one uses to justify application of any technique within the helping relationship is the first step to applying those techniques with greater effectiveness.

There is considerable information written that describes qualities and characteristics of the helping relationship for those who are about to become human service professionals. Whether training to be a social worker, a therapist, a nurse, or a teacher one can find literature offering guidelines on how to develop an effective helping

relationship¹ within the guidelines for that profession. Unfortunately this information is often technique oriented and does not address the underlying factors that govern how one justifies the application of technique. It is the process of choosing what to do and when that is behind the development of a quality support relationship. There are few descriptions of the differences between the three types of relationships people will encounter when seeking to offer help (healing, support, habitual). A quality support relationship is recognized as critical to the person's well being, but often there is little training provided in the fundamental factors governing this important relationship.

The human service worker helping the individual does so within the individual's environment, and within the human service environment, with the aim of soliciting appropriate thought, actions, and supports to help the individual attain the greatest degree of independence possible². This movement toward greater independence is based on the application of a wide, eclectic range of techniques to stimulate such movement. ***Behind the selection of techniques the practitioner uses to help another, the choices of when to use them, and when not to use them, are the three models of mind, change and relationship.***

A quality support relationship should be viewed as eclectic³, drawing from multiple sources of information and applied in a holistic fashion. The support relationship might include developing cognitive aids for the person (e.g., a memory notebook, use of a alarm watch, or use of a check-off list) and it might include helping the person with the one or more of the following: daily living skills, leisure activities, work or school accommodations, relationships skills, social skills, money management, and behavior management. It might also include helping the person with their emotional processing (e.g., anger management or coping with depression and anxiety). It may also include helping the person to re-enter the community with the teaching of person-centered social skills and specially designed job accommodations. As stated previously, the support relationship might

include helping the person to reflect on their wellness journey including understanding wellness seeking, extending wellness duration, and building support for wellness duration.

The effectiveness of support offered by the human service worker is proportional to how well this support matches the individual's needs. This is the "rule" (or basic assumption) of healthy support excellence.

R.3: The Rule of Support Excellence

Excellence in support is dependent on how well the support matches the person's needs.

There are two principles that follow from this rule:

Principle 1 (p.1): The better we understand the individual's needs the higher the likelihood of quality support.

Principle 2 (p.2): As we find ways to better know the individual we increase the likelihood of understanding the individual's needs better.

In order to offer excellence in support relationships the human service worker should strive to understand the person's needs. In order to come to an understanding of the person's needs the human service worker should understand the following:

- How the individual in need processes information
- How person in need sees and experiences the world.

- The way person seeking help changes, grows, develops and responds to help.
- How the person giving help comes to know the person in need.

Restated, we as helpers, shape how we come to understand another through our own filters of past experiences. How we understand how another person processes information, how another sees and experiences the world, and how the person responds to help is directly related to our history of knowing others. If we can know how we filter our understanding of another in the support relationship, then it is possible we can take steps to improve the quality of that support relationship.

As an example of how these principles work within the support relationship we can look at providing support to a person with a cognitive disability (like Alzheimer's). Over the past decade there has been an increase in the need to provide clinical and support services to individuals with neuropsychological deficits⁴. The human service worker asked to provide such a service ethically must use a set of hypotheses about the individual's issues as a way of matching their helping approach to the individual's need⁵. In performing this match of support to need human service workers helping people with the cognitively disabilities should learn not to assign inaccurate attributes to the individuals⁶.

For example, a person with a cognitive disability may be seen (in the morning) coming out of their room with her pajamas on. The helper asks her to go back into the room and to get dressed. She agrees and returns to her room. A few minutes later she returns, still in pajamas. The helper repeats the instructions. She agrees to get dressed and goes into her room, but after a few minutes comes out still in pajamas. The staff have witnessed her getting dressed on her own (one day last week), so they are convinced that "she can do it if she wants to". This assumption is based on a model of mind that the

staff use – the observed behavior is linked to willful act. Accompanying such assumptions are possible inaccurate attributes: she is capable but just not willing, or she is capable and she is being manipulative. Again the model of mind is applied – the staff now makes assumptions of what is happening with the person’s thinking and why she is behaving the way she does. It is common in the business of human service. The staff might then respond by implementing change models based on these assumptions. These could include verbal scolding or withholding reward because of the assumption of manipulation.

In this particular instance, it might be discovered that the person needing help getting dressed had an attention deficit. Upon entering her room she would get distracted and lose the ability to concentrate on the task of getting dressed. A different model of mind is applied. Hanging visual signs in her room would help keep her with attention focus and improve her self care performance. A different model of change is applied.

Assignment of inaccurate attributes, using inappropriate models of mind and change, can lead to providing training and support that is not needed and often not desired by the person requesting help. This leads to examples of unhealthy support relationships that do not foster wellness. We need to ask ourselves how do we acquire information about the individual’s needs, how do we think of change in order to help the person meet these needs, and within what type of relationship to we do both.

From whom do we get the information we use to offer help within the support relationship? How do we use this information? Are there sound principles behind the process of gathering information about the person’s needs? As human service workers we enter the support relationship with a foundation of knowledge that shapes the decisions we make on how we are going to offer help. We bring all of our training, our past, and our personality into how we provide support for another.

Researchers agree that human service workers need more information in order to provide a higher quality service for persons with disabilities⁷. Because we have no language that can be used to facilitate conversation about the principles needed to build quality support relationships we are often faced with not even knowing what questions to ask as we seek to improve how we provide help. Sometimes we do not improve because we do not know what direction improvement might take. When seeking to improve the quality of the support relationship the human service worker should ask the following questions:

1. Does the person need therapy (counseling)? Is the therapy they currently receive meeting their needs? Is relationship or family counseling needed? Is medical consultation needed?
2. Does the person display any behaviors that could place him/her at risk for self-injury: are they safe crossing the street, safe with movement, safe while cooking, do they exhibit self-injurious behaviors, uncontrolled impulsive behavior or suicidal talk? Is there a written plan of action to address the risk? Is the plan written so it is easy for people to understand yet commensurate with the principles that underlie healthy support relationships? Are all support persons trained regarding this plan?
3. Does the person display any behavior that could place other persons in the community at risk: do they exhibit inappropriate sexual behavior, aggressive behavior, stealing, poor use of social space or wandering or violence toward others (or property)? Is there a written plan in place to address this risk? Is the plan written so it is easy for people to understand yet commensurate with the principles that underlie healthy support relationships? Are all support persons trained regarding this plan?

4. Has the person improved since you have known him/her? How has s/he improved? Is this improvement documented? Is there a written description in place to access what we know of this improvement process so that this knowledge can be used across settings and among support staff? Do we know how this person improves and can we continue to support him/her with choice, participation, and achieving the highest quality of life possible? Have we described the link between improvement and our ability to share communication with the person? Are all support persons trained regarding the nature of the person's improvement process?
5. If the individual is working or engaged in public leisure activities have we designed the best accommodations possible? Do the support people know how best to provide this accommodation and support? (Do we access the information from question #4?). Do we have information that clearly describes the cognitive-behavioral-emotional needs of the individual so that we can design the best accommodations? Can we improve how we train people so that they can better match support to the cognitive-behavioral-emotional needs of each person?
6. Can we move from reacting in crisis to knowing how to prevent crisis? What steps would need to be taken to prevent a crisis in the life of the individual receiving service? What information is needed in order to take these steps? Can we design a support plan to help the person stay out of crisis and train staff on this plan?
7. Is there an individual with whom you work (or live) that requires an abnormally large amount of your support

time? Why? What steps need to be taken to help that individual become less independent on systemic supports and more connected to natural supports? Is more independence a person centered goal? What information is needed to accomplish the goal? What is the nature of “natural” supports around the person and how can these supports help the person toward a higher quality of life?

Answering these questions requires an understanding of how one uses the helping relationship to acquire these answers. A systematic method of acquiring answers to the above questions should be part of providing quality support relationships. Finding the answers is a process of 1) discovering the persons needs, then, 2) following along person-centered problem-solving paths to eventually 3) arriving at person-centered goals aimed at achieving a higher quality of life, and/or improved well being, for the individual receiving support services and 4) appropriate delivery of techniques to support the person in meeting the person centered goals. These four steps are tied to the term **person-centered support**. The delivery of a quality support relationship is based upon the delivery of quality person-centered support as it is connected to our utilization of the three models.

The *STUF*(f) we bring into Person-Centered Support and Its Connection to the Three Models

The process of person-centered support happens through the application of the three different helping relationships (healing, support, habitual). In each of the three relationships we use communication skills, and various teaching strategies, while being compassionate, in order to provide person-centered support. When providing help to another, whether as direct care worker or clinical supervisor, we each enter into one of the three relationships as a way of discovering how we can provide the best possible support. However, in entering the helping relationship, we bring a history of what it means to provide help to another. We also bring a history of our own personal relationships, which includes encounters with the support relationship. What we may not realize is this history of offering help within relationship contains *STUF*. This *STUF* is a collection of ideas and concepts that shapes how we view the helping relationship. It is *STUF* that is shaped from our models of mind, change and relationship.

Whether we are aware or not, we use this *STUF* while providing person-centered support. The term *STUF* refers to **S**elf, **T**ools, **U**nderstanding and **F**riendships. When we enter the helping relationship we bring our concept of self (S), a set of interpersonal skills, helping relationship tools (T), a level of insight and empathy for understanding mankind (U) and a past history of relationships, or friendships (F). Each piece of *STUF* we bring is connected to the three models – mind, change, and relationship – that we use when we offer support to another person.

S – The Self (self concept)

Volumes have been written on the concept of self⁸ and it is beyond the scope of this text to enter into an extended discussion on the subject. What is relevant to this presentation is that the helping relationship is affected by not only how human service workers see themselves, but also how the individuals seeking help see themselves. Two people enter into the helping relationship both bringing their own self-portraits, their own views of themselves and these self-views may clash – particularly when they differ considerably.

The influence of self-concept on the developing nature of the helping relationship is strongly evident when the two people are from different cultures. If the helper is from America and trained in our human service culture and the individual is from the East (e.g., Japan or India), there can be a clash in their understanding of self-concept that is deeper than any shared conversation. There can be different self-views associated with the clash between the medical model and a holistic healing model.⁹ Sometimes people seeking help have a self view that is tied to a long history of being connected to a system of “support”, or what has been referred to as the “culture of mental health”.¹⁰

For example: If a person has had trauma to the brain there may be a struggle with the sense of self that follows trauma to the brain. The person remembers what it used to be like to be their former self (before the trauma), but now this person’s self is not the same and people are reacting differently to this new self. In addition, the person may have experienced a history with practitioners during the recovery that has shaped his/her view of the role of self in the healing process. As a practitioner we need to understand this person’s struggle with self-concept as a part of providing person-centered support. Any help we offer has the potential for adding to the struggle or helping the person with growth through the struggle.

Certain individuals seeking help have been involved with support services for decades. This long-term involvement can leave imposed effects, such as those related to having lived within the culture of an institution and having developed certain patterns of thought and action related to institutional life (e.g., hoarding behaviors). There is also the culture of health care into which the person has become indoctrinated, where there have been “professionals” in and out of the person’s life, which have not only shaped self-concept but also shaped the idea of self determination. What may seem as a reasonable goal of independence from the practitioner’s self-view may not fit the person’s self-view. It is very likely that persons indoctrinated in this manner have a different sense of self than most human service practitioners. If the human service practitioner assumes that his/her concept of self can be directly applied without thought toward change, then person-centered support will not be achieved.

There are many different ways that a person’s background can result in a sense of self that is different from the practitioner. A person’s sense of self can be shaped by influences from living in poverty, or coming from an abusive home, or substance abuse. These are influences that can change the person’s sense of self worth and their sense of safety when seeking help. There may be different culturally influenced perceptions of how one is to ask for help, and who one is to trust, as when dealing with people who define self as related to soul and spirituality and who don’t trust help that is not oriented along these lines. In addition, some persons have not yet developed (or have lost) the skills needed for self-insight and, as such, possess a different self-concept than the practitioner. This clash of self-views can impede the development of quality support relationships.

Addressing both cultural differences, and self-view differences, is a part of providing person-centered support. How individuals experience self-concept effects not only their understanding of themselves in relation to the world, but also their expectations of

themselves as they enter the helping relationship. A person with a very low self-worth, or a person with limited self-insight, will have expectations of the helping relationship different from a person with strong self-worth. The practitioner's self-view may not match the person's view. The human service worker entering into a helping relationship needs to come to an understanding of the individual's self-concept, how it differs for the practitioner's view, and how the clash affects the helping relationship.

But how do we come to know the self-view held by the person seeking help and its differences from our self-view? Again, we will use our own models of mind, change, and relationship to acquire this knowledge. We will gather information about, and interpret, how the other person thinks about self (self-concept) and maybe draw upon examples from our observations of the person to support our ideas about his/her self-concept. We may take these observations and use them in combination with our own ideas about mind (how one would think about self) to generate ideas about the person's self-concept. Since we are practitioners, and we offer support in hope of promoting change, we may also have some ideas about how the person's self-concept interacts with the change process. Is the person presenting as helpless and presenting with such a low self esteem that seeking change toward independence seems impossible? Our model of change, of how we think the person could change, interacts with our understanding of the person's self-concept (which is related to our own self-view). Our understanding of the person's self-concept is related to how we form a relationship with that person.

As a trainer of practitioners, I have observed that one of the most frequently occurring deterrents to a quality support relationship is projection of the self onto the other within what is supposed to be a helping relationship. What happens is that the helper feels something (or thinks something) and assumes (without further examination) that the other person is feeling it (thinking it). This can happen even if the helper is not aware that they have these feelings (or thoughts) inside themselves. For example: An individual come in to talk about the

trouble she is having with a relationship. The practitioner hearing her talk about the relationship problems thinks of personal past relationship problems and feels anger. The practitioner then assumes that the individual is also feeling anger. The practitioner may also assume that the steps the practitioner took to resolve past relationship problems are those that should be applied to this individual. This projection of the practitioner's inner state onto the helping relationship can be quite problematic when there is a poor fit, when the practitioner's feelings and proposed solutions don't meet the needs of the individual requesting help.

The idea that we may use our present understanding of relationship, and our state of self-perception to identify another's state is not unusual – we often perceive others through our own eyes. What is important to note is that as practitioners we can become so intent on offering help that we can forget the strong influence of our self-perception on the design of that help. When we forget this self-influence there is the risk that the help is more practitioner-centered than person-centered. In addition, as discussed above, it is important to recognize that our understanding of self-concept is likely to be culturally, and historically, different than the person we are helping. We can become attuned to the differences in self-concept and their effects on the providing person-centered support. With such insight we can move toward building quality support relationships. Further discussions of self-worth and its connection to well being is provided within “The Habitual Relationship” (Document Three).

T – Tools (techniques of change)

When we are asked to help another we are also asking ourselves, “How will I help this person? What will I do to help?” Each of us enters the helping relationship with a set of helping tools, things we do and say that we think are part of what it means to offer help to another. We have our own style of communication, our preferred

techniques (including patterns of behavior or rituals), and an explanatory system behind the techniques we use that are included within how we provide help to another. Each of us, when we have agreed to answer the call to help someone, does so with a set of preconceived ideas about what type of help to provide and why. We enter the support relationship with our model of change.

When helping another we generally talk to the other person about the help that the person is requesting. During this helping conversation we use a particular style of communication, and apply our communication tools in a manner we think provides help. How we use these communication tools will have different effects depending on how we apply them during the delivery of help. We each have ways we introduce ourselves, ways we react to each other, styles of negotiation (direct or diplomatic) and different ways of processing information during conversation that result in varying conversational content from person to person.

Some of us have conversational skills that have been culturally shaped, e.g., using street slang, or having a strong accent. There are interpersonal skills (or phrases) that are common to the culture of health care, e.g., “taking responsibility for your own actions” and “do no harm”. Most human service professionals are trained to use a certain type of dialog within the helping relationship, and to communicate with a professional dialog among their peers. This professional dialog changes in character when one crosses helping fields. For example, the clergy, or alternative medicine practitioners, use a professional dialog quite different from physicians. Not only is their professional dialog of helping different, but also the ideas behind the dialog – the ideas about what contributes to change and how “I” (the practitioner) can contribute to the process of helping “you” (the participant). What is important to understand is that the set of interpersonal tools we bring into the support relationship, and the ideas about change behind these tools, or our model of change, will effect how the support relationship develops.

When we enter the helping relationship, carrying our own communication “toolbox”, we should be aware of the interaction between this “talk toolbox” and the quality of support provided. In general, the talk toolbox can be considered to contain tools, or techniques, grouped under three headings: 1) attitude, 2) technique, and 3) experience. This general grouping of the support relationship tools will be explained in more detail within a later chapter.

Support Relationship Tools

(the T of *STUF*)

Attitude: Conditions and intentions

Technique: The ABCS of change
(**a**ffect, **b**ehavior,
cognition, **s**piritual)

Experience: “Flow”¹ and process

Attitude refers to the attitude that the human service worker brings to the support relationship. It also includes how we approach, or assess, the presenting call for help. It is how the practitioner enters into the support relationship in response to the call for help. The practitioner enters into the support relationship with certain characteristics, certain intentions, and who also, through their presenting attitude, establishes boundaries. Attitude can take many forms, changing as we offer help to different people, and as we repeatedly provide the service to one person. We can enter the support relationship with a preconceived idea of what could happen, or what should happen, only to discover something else happening when we get there. We could develop a cold and distant “professional” attitude as the way we enter the support relationship.

Perhaps we enter with the attitude of “mother as care giver” or “father as rule giver”. Perhaps we enter with the attitude of the “fixer” or the “advice giver”. Attitude is affected by the intentions we have for the support relationship. Perhaps we wish to help the person stop acting badly, or to improve their self-care, or to live a happy life, or to help them with their progress (in what ever way we define and observe progress). Each intention we bring to the support relationship will affect our attitude while in the relationship. Both attitude and the underlying intention will affect the course of the support relationship. Building a quality support relationship, and using technique wisely, starts with understanding how our attitude is one of the tools of change. Attitude should be included within our model of change along with an understanding of proper technique application.

Technique refers to the collection of verbal and non-verbal skills one uses within the support relationship to assist individuals in fulfilling their request for help. This toolbox of skills includes our interpersonal skills (how we interact with people), the tools we use to facilitate (negotiate, mediate) the delivery of service in order to meet the individual’s needs, and our counseling skills. Counseling skills, in this sense, refer to a broad set of communication skills the helper uses to assist the individual in meeting their **affective** (emotional), **behavioral** (actions), **cognitive** (thinking), and **spiritual** (faith) needs (the ABC’S of change). The analogy of “toolbox” can be applied as one may visualize reaching in and taking out a specific technique to address a specific individual’s concern. The technique used for helping a person through grief (affective) would be a different tool from the one used to help improve memory (cognitive). The tool used to help the person with an attention problem (cognition) might be different than the one used to improve faith or to resolve a spiritual crisis (spiritual). The eclectic practitioner will have in his/her toolbox tools representing the ABC’S. It was stated in “The Healing Relationship” that there are thousands of schools offering a wide variety of techniques. The collection of tools a human service worker has in his/her toolbox will vary depending on personality (the

practitioner's particular orientation) and past experience (including training and cultural influence).

Orientation and past experience not only effect the type of tools collected and their diversity but also their utilization. Experience shapes the differences between the novice human service worker and one who has been working with the helping relationship for more than a decade. The experienced human service worker has more to draw upon when asking, "What tool do I use now?" This is not to say that the more tools one collects the more skilled they will be at providing quality support. Instead experienced practitioners have gained, through decades of practice, an understanding of when to use what to achieve person-centered support. This "when to use what" concept is part of their model of change.

Experience is also shaped by an interaction of predisposition and opportunity. Some people are more predisposed to human service work and are likely to be more successful in providing a quality support relationship. Success with the support relationship yields positive feedback that then stimulates a search for more opportunities to practice these skills. The more one finds opportunity to expand his/her understanding of, and skill in using the support relationship, the more one's experience is enhanced.

Initially, experience with the support relationship is applied in learning about the affects of attitude, building an ABC'S toolbox, and learning how the ABC'S tools are applied. After many years of offering the support relationship to others, if you are so blessed, you may begin to experience moments of **flow**.¹¹ These are times when the support relationship flows smoothly, effortlessly arriving at a growth-fostering moment, seemingly without thought. It is like the star basketball player who during the game can't miss a shot. He is in the "flow". He didn't have to think about every action, but rather flowed with what was happening to achieve a successful outcome. Experience can be seen as a tool, as in this concept of flow, but it is also something that enhances the application of one's helping

relationship tools. Through experience, which adds to wisdom, it is possible to have moments of “flow” within the quality support relationship. Movement in the direction of building a quality support relationship involves expanding one’s experience in the direction of “flow”. Understanding that there is the possibility of experiencing “flow” moments within the support relationship, and understanding their significance, can be part of one’s model of change and one’s model of relationship.

The concept of flow as a tool has another connection to the idea of change. Change, over time, has a flow or a movement. Over time, the process of human change can be observed. Observations of this change process, by either the participant or the practitioner, can be helpful in developing quality support relationships. This idea of monitoring change as a process (or flow) and using that information to assist with support can be part of a person’s model of change.

U – Understanding (knowing another)

The four steps of providing person-centered support are:

- 1) discovering the persons needs, then,
- 2) following along person-centered problem solving paths and eventually
- 3) arriving at person-centered goals aimed at achieving a higher quality of life, improved well being, for the individual and
- 4) appropriate delivery of techniques to support the person in meeting the person-centered goals.

The delivery of quality person-centered support is dependent upon our understanding of the other person’s needs.

When the person asks for help we need to know what are they asking, what needs are not being met, and how can we support the

person in meeting those needs. Understanding another (the U of *STUF*) should first be considered as our understanding of the person in need – discovering our own answer to the question of how do we come to know the needs of the other person. Sometimes this is as simple as listening to the person’s requests, but sometimes the request is not the need, or the request is acted and not stated, or others state the request. In addition, we need to realize that our model of relationship and our model of mind affect coming to an understanding of the other’s needs. How we come to know another in need is effected both by how we sit in relationship to that person and also by how we think about the person’s thinking (our attempts to answer, “Why did they ask for that? or “Why do they act that way?”).

This type of understanding, or knowing another’s needs, should be under-lain by wisdom and compassion. Wisdom in the helping relationship refers to the thought processes we use when we are seeking to make sense of our interactions with the other person (our model of mind and our model of change). Wisdom is demonstrated through the system of judgment-making we use when decide how we will seek to know the other person, what we will do in order to discover what supports are needed, and what we will do in our efforts to deliver those supports. This judgment-making system is influenced by the other *STUF* components and is strongly affected by our ideas on how people change. Our ideas on how people change are influenced by our internal concept of mind, by our model of mind. Compassion refers to empathy, sensitivity, how we listen with our heart rather than just our head (our model of relationship). Wisdom and compassion combined can provide a sound foundation for coming to know the person we are seeking to support.

We each construct, in our thoughts, a model that we use to help us explain why people do what they do and how they might change (or refuse to change). We say that this person did, or said, something because they were upset. We say that a person behaved that way because they couldn’t help themselves – look at the environment this person lives in. We might even say that a person behaved that way

because it was exactly what is to be expected from “those kind of people”. Some of us might have more sophisticated labels that call on different personality types (e.g., criminal, introvert, extrovert) or various diagnoses (e.g., autism, Down Syndrome, depression) and we may use these terms as part of how we explain why people do what they do. Some of us may have a model with a stronger spiritual component, linking changes in faith to changes in behavior. Some of us may have a more mechanistic model, linking changes in behavior to nerve responses and chemical changes, or a behavioral model linking actions to antecedents, rewards and aversive stimuli. When we seek to explain why people behave the way they do, we frequently discover the explanation through the application of our own model of mind.

This explanation, or model of mind, often serves as a foundation for the rationale used in describing what supports we are providing. The model of mind also supports our rationale of how we link the supports being provided to the person-centered change process. If we think that a person is behaving a certain way because they are being “manipulative”, then we would propose one course of action. If we think that person has a cognitive disability, including a possible mental health problem, then we might propose a different action to support change. If we think that there is an emotional cause (the person is very sad today), then something different might be suggested. There is often a direct link between our application of our model of mind, our explanation of human behavior, and how we offer support to person in need. This application of model of mind is significant when working with persons who have cognitive disabilities because, by definition, they have “mind impairments” that should be able to be explained using our model of mind. If we have such a model of mind that helps to explain the range of effects associated with these cognitive (and mental health) disabilities, then it should be easier for human service workers to match supports to individual need. With an improvements in the matching of supports to need, there will be movement toward more healthy support relationships.

Coming to know another in need is critical to the process of matching support to need. Wisdom is often balanced with compassion as part of this coming to know process. Our model of relationship influences the use of compassion, as part of the way we understand the person in need. How do we understand entering into relationship with another? Our personal model of relationship is one that we use to describe to ourselves the nature of this person-to-person encounter. Within the support relationship we use our model of relationship, which includes some definition of the role of empathy including our definition of empathy.

We each experience empathy slightly differently, and as such, we have each constructed a different model to describe the nature and boundaries of empathic understanding. We each have our own empathy model and we use that empathy model to structure the boundaries and limits of the compassion we share within the support relationship. Empathy is something that can be developed or expanded, and, as it is expanded, used to improve the healthy qualities of the both the support relationship and the healing relationship. The issues surrounding the importance of empathy within the healing relationship, the idea that it can be expanded and taught, were discussed in detail within “The Healing Relationship”.

F – Friendships (relationship history)

When someone asks for help, and we answer him or her, we enter into relationship with that person. The relationship we offer to others is shaped by types of relationships we have encountered within the friendships of our lives (the F of *STUF*). Past relationships shape our sense of compassion, trust, our interpersonal skills, and our definition of empathy (see “The Healing Relationship”, Document One). We bring with us our own relationship luggage into the helping relationship. Some baggage we may clearly see, and some is hidden. It is baggage that is full of *STUF* and this baggage can triggered us to

enter into the habitual relationship instead of the support relationship or the healing relationship, sometimes without our full awareness. Our history of relationships has a strong influence over our ability to offer quality person-centered support.

Suppose you had been treated badly in the past by our grandfather – a gray haired, old grouch. Now, as a human service helper, you have been asked to visit an elderly man's house each morning to help with his daily care and meals. At first you think nothing of it, but when you arrive the old man is a grouch. You become defensive, sometimes argumentative, and you leave feeling angry. This is certainly not a description of a healthy support relationship (it is an example of a habitual relationship). Another example; consider, that you had a wonderful relationship with your younger brother. He was kind, caring, and compassionate. The times you shared with him were full of fun and you always felt closeness with him. Now you are asked to work with a young man diagnosed with Down Syndrome. The young man is pleasant and the two of you communicate well. After a few visits you begin to look forward to seeing him, perhaps taking him on special trips. If other support people in his life take vacation you request to spend more time with him. You spend time at night thinking of ways to help him. If other people are providing him with support you find fault with how they do it and sometimes you feel angry. Although this is clearly different from the service to the older man, it is no different in terms of bringing one's personal baggage into the offering the helping relationship.

We all bring some form of baggage into the helping relationship. The difficulty is in recognizing when we do this and then changing both our behavior and our thought patterns. This baggage we carry can be full of strong habits that are both hard to see and hard to change, but change is possible. Defense mechanisms can provide barriers that inhibit the change process. In order to build healthy helping relationships you will need to change the effects of your *STUF*, and you may need help to do this. You will need to understand

the role of your own models of mind, change and relationship. You will also need to recognize the difference between the support relationship and the habitual relationship and how your movement in and out of each has a connection to past relationships. The hardest part to learn about the influence of past friendships is that the influence can be to recognize, and the habits can be long-standing and often very hard to change.

The *STUF* we bring into the helping relationship includes the models we access when we offer help to others. The way we see ourselves in relationship to others is related to our concept of self and the interpersonal and training skills we use. How we see ourselves in relationships and the communication skills we use are connected to how we understand others and to how our past relationships effect us. How our past relationships effect us, how we use our tools, and our understanding others are related to the three models we use throughout our lives – the model of mind, the model of change and the model of relationship.

The model of mind is the model we use to help us explain the causes behind others actions, to answer the question “Why did they do that?” or “What are their needs?” Understanding why someone did something and what do they need is often the beginning point for addressing change. The model of change is what we use to describe why we have chosen a given approach to help, or teach, someone. We use it when we answer for ourselves the question “What can I do to help this person?” The model of relationship is used when we sit with another to discuss helping him/her to meet their needs. We have a certain idea of how we should present ourselves to that relationship and how that relationship is connected to the practice of helping.

As human service practitioners, we have each acquired certain tools, ideas or approaches within our concept of what is the best approach to use when helping someone meet their needs. We have ideas about the nature of human change (both for ourselves and for those who are seeking help). As we apply our model of mind and our

model of change in an effort to help another we do so within a relationship – a relationship affected by our concept of what a healthy helping relationship can become. We also have an idea of what it means to be “connected” to another. These are ideas about friendship, intimacy, safety, relationship boundaries, love, compassion, and sensitivity. These ideas are part of offering a helping relationship and fall within our model of relationship. These three models of mind, change, and relationship affect how we offer person-centered support.

This brings us to the next rule governing the development of quality support relationships:

R.4: The Rule of Model Application

Support relationships are built upon how we apply our models of mind, change and relationship.

There are four principles related to this rule:

Principle 3 (p.3): Lack of awareness of how one applies their models of mind, change and relationship often affects the quality of person-centered support.

Principle 4 (p.4): Poorly constructed model concepts often result in inefficient application of person-centered support.

Principle 5 (p.5): People are often resistant to changing their model concepts even when more improved models are presented.

Principle 6 (p.6): When people learn about, and integrate improved models into their way of applying person-centered support, the quality of the support is likely to improve.

In order for us to provide higher quality support relationships we need to become fully aware of the *STUF* we bring into the relationship. The *STUF* we bring into support relationships is connected to our models of mind, change and relationship. In order to address our *STUF* we need to understand how we use our models of mind, change, and relationship.

An example of the model application issues a human service practitioner might face follows:

A middle aged male, comes to the human service practitioner for help. Three years ago he had triple-bypass heart surgery. He had considerable pain following this and prayed for relief. An answer came in the form of a vivid dream of a woman holding a cross. He felt uplifted by this vision and his pain disappeared. It was a miracle and confirmed his faith in God. Over the next few years his love of life progressively got worse as he discovered how “mean” people could be, and how angry he could get. This disgusted him. He started drinking, and his drinking became heavy. He had a “falling-out” with his siblings and parents, blaming them for his self-disgust because they never supported him. They always made him feel like a failure. Memories of childhood sexual abuse became more vivid and added to this feeling of disgust. He has been living with his second wife for 25 years, but recently they have not been communicating well. His children are grown and out of the house. He has two grandchildren whom he loves. He has been employed at the same place for the past 15 years and does not feel appreciated at work. He has stopped doing all the things he used to that brought him pleasure. He states that he cannot go on living this way anymore. He has never been to counseling (or AA) and doesn’t attend church. He is crying often, doesn’t sleep well, and has difficulty maintaining concentration of the flow of

conversation, but he is not suicidal nor is he at serious medical risk. He is seeking help to end his suffering.

This man is suffering and he is asking the human service practitioner for help.

How is the practitioner to approach the question of providing help for this man? As we answer this question we draw upon our own models of mind, change and relationship. Before we can provide help we need to understand this man and in understanding this man we will enter into a relationship with him. Our model of relationship (how we form relationships that promote well being) effects the relationship we form with this man. Once the helping relationship is established, we then seek to interpret this man's suffering in an effort to determine the appropriate help. Is there a cause for this man's suffering and if there is then what other evidence do we have to address this cause that will help to promote well being? Our model of mind helps us to interpret the nature of this man's suffering, to understand his suffering so that we may help. But, how we apply our model of mind effects our interpretation of this man's suffering. What do we think is troubling this man and why? Once we have answered these questions we then apply our model of change. When we offer to help this man we are offering to help him change his current relationship with suffering. There are many different models of change that could be applied to help this man attain a new relationship with his suffering. Which model will the practitioner apply and why? Answering these questions is a part of providing a quality support relationship.

Going beyond Our *STUF* – Developing the Three Models

This introduction presents the idea that healthy support relationships are based on not only our interpersonal skills but also on how we come to know the person seeking help, in particular to how we understand his/her needs. The quality of the support we provide is

proportional to how well we fit the support to the person's needs. The match between support and need is linked to our knowledge of the person. It is proposed that our coming to know the person involves three models – the models of mind, of change, and of relationship. Through understanding our own models and learning new models, we can learn about the *STUF* we bring into the helping relationship and move toward providing quality person-centered support. As we seek to develop our models of mind, change and relationship we can make model comparisons to those others use. We can keep portions of our models that seem to work well and we change the parts of our models that seem rigid and inefficient. We can change our old models into new ones. We can learn how our old models are intertwined with our *STUF* and then, hopefully, decrease the impact of our *STUF* on the quality of support relationships.

Advancing one's learning about healthy support relationships includes expanding one's understanding of their own models of mind, relationship, and of how we think human beings change. Knowledge of our own models helps us to more accurately assess the way each of us constructs the support relationship. It is knowledge that can be used to improve the quality of the support relationship. This text will offer a description of the guidelines that should be considered when developing one's model of mind, of change and of relationship. These guidelines are presented in an effort to stimulate human service practitioner into thinking about their own models.

The information included in the description of these three models is meant to serve as one part of a three-part instruction manual on healthy helping relationships. The models present general guidelines, like the rules and principles presented in this introduction. Specific treatment instructions related to specific problems or diagnoses (e.g., Alzheimer's, autism, ADHD, schizophrenia) are not part of this text. But it is expected that human service workers who become familiar with the rules and principles described within this text will be able to expand their own models of mind, change and relationship to provide support for meeting specific individual needs.

As they modify their own models and apply them to specific individual needs, it is expected this will improve the quality of the support relationships they offer. Learning and understanding the rules and principles described herein allows human service workers greater flexibility in tailoring each support relationship to each individual's needs. Such an approach decreases the risk associated with a "cook book" method for treatment toward a given diagnosis. The approach of developing the three models allows human service practitioners to build a treatment approaches based on the founding principles that underlie all healthy support relationships. This may decrease the frequency of harm connected with human interaction and increase the frequency of interactions that promote well being.

There are times when it is dangerous for the practitioner to be in the role of offering the healing relationship, for example when the healer moves into the dark suffering of another simply to help that person feel better, without a contract of healing offered. Yet there are times, in the business of providing human service, where practitioners are asked to do just that. It is during these times, when the person seeking help cannot move into the healing relationship yet wants to get better, that the quality support relationship needs to occur. It is during these times we need also to avoid entering the habitual relationship. If we can continue to offer the healing relationship whenever possible, provide quality support relationships at all other times, and avoid entering the habitual relationship, then we will be providing help that promotes well being. Every practitioner will develop his/her own style, his/her own toolbox to use while delivering the support relationship. Behind this style, behind the use of the toolbox, are the three models of mind, change and relationship. Learning how to work within one's style in a manner that provides quality support requires learning about one's use of the three models. Learning this, along with knowledge of the three relationships, is the journey of becoming a skilled practitioner/facilitator of the helping relationship that promotes well being.

Additions to this document are under construction. These additions will discuss the three models (mind, change, relationship) as they affect the development of a quality support relationship.

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Leay, M.J., Szymanski, E.M. and Linkowski, D.C. (1993). Knowledge importance in rehabilitation counseling. Rehabilitation Counseling Bull, 37, 130-45. Any one who is in crisis, who is stuck in suffering and can not see a way out, could be considered as temporarily having a disability – meaning that they are not able (dis –able) at that time to discover how to help themselves.
- ⁸ For example see Taylor, C. (1989). Sources of self: The making of the modern identity. Cambridge, MA: Harvard University Press.

⁹ The different self-views associated with the clash between the medical model and a holistic healing model was discussed in chapter five in document one.

¹⁰ Fancher Fancher, R.T. (1995). Cultures of healing: Correcting the image of American mental health care. NY: W.H. Freeman & Co.

¹¹ Ibid

