

1. “When I Feel Stuck With a Client” Guide

Purpose:

To help clinicians pause, reflect, and identify next steps rather than pushing forward without clarity.

Reflective prompts:

- What part of this work feels unclear or challenging right now?
- Is this about the client’s presentation, my response, or the therapeutic relationship?
- What emotions am I noticing in myself during or after sessions?
- What might this client be communicating beneath the surface?

Next steps:

- Review treatment goals and progress
- Consult with supervision
- Consider whether a different modality or pace is needed

2. Risk Assessment Decision Aid

Purpose:

To support consistent and thorough safety assessment.

Key questions to consider:

- Is there current suicidal ideation, intent, or plan?

- Are there historical risk factors that elevate concern?
- What protective factors are present?
- Has risk increased, decreased, or stayed the same since last session?

Clinical reminder:

When in doubt, slow down, document clearly, and consult.

3. “Do I Need Consultation or Supervision?” Guide

Purpose:

To normalize consultation as part of ethical practice.

Consultation is recommended when:

- You feel stuck over multiple sessions
- Risk feels unclear or elevated
- Strong countertransference is present
- Progress has stalled despite consistent work
- You’re unsure about diagnosis or level of care

Reminder:

Seeking consultation is a strength, not a failure.

4. Diagnostic Clarity Aid

Purpose:

To support accurate and ethical diagnostic decision-making.

Reflective questions:

- What symptoms are most impairing daily functioning?
- How long have symptoms been present?
- Do symptoms align with diagnostic criteria?
- What alternative diagnoses should be ruled out?

Best practice:

Use client quotes and functional impact to support diagnostic justification.

5. Treatment Plan Alignment Aid

Purpose:

To ensure goals and objectives reflect what is actually happening in therapy.

Check alignment:

- Do treatment goals match the presenting problem?
 - Are objectives specific and measurable?
 - Do interventions align with stated goals?
 - Has the plan evolved as the client has evolved?
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6. Documentation Decision Aid

Purpose:

To support clear, ethical, and protective documentation.

Ask yourself:

- Does this note tell the story of the session?
- Is it clear what the client brought in and how I responded?
- Does documentation support continuity of care?
- Would this note make sense to another clinician?

Reminder:

Documentation protects both the client and the counselor.

7. Level of Care Consideration Aid

Purpose:

To help clinicians recognize when additional or different support may be needed.

Consider higher or different levels of care when:

- Symptoms significantly impair daily functioning
- Risk increases or becomes difficult to manage outpatient
- Progress remains limited despite consistent intervention
- Additional structure or support is clinically indicated

Consult with supervision before making changes.

How to Use These Aids

- Use them as prompts, not prescriptions
- Return to them when things feel complex or uncertain
- Pair them with supervision and consultation
- Document your clinical reasoning when decisions are made

When I Feel Stuck With a Client

Beyond the Mirror Counseling & Wellness

Feeling stuck with a client is a normal and meaningful part of clinical work. It often signals that something important is unfolding and deserves curiosity, reflection, and support—not urgency or self-judgment.

This guide is designed to help you slow down, reflect, and identify next steps when sessions feel unclear, repetitive, or challenging.

Step 1: Pause and Name What Feels Stuck

Take a moment to gently identify what feels challenging right now.

Ask yourself:

- What specifically feels stuck or unclear?
- Is this about progress, direction, the relationship, or my internal response?
- Has this feeling persisted over multiple sessions, or is it new?

Naming the stuck place is often the first step toward movement.

Step 2: Reflect on the Clinical Picture

Consider the client's experience and presentation.

Ask yourself:

- What might the client be communicating beneath the surface?
- Are there themes repeating in sessions?
- Has anything shifted recently in the client's life or symptoms?
- Do the current interventions still align with the client's needs?

Review the treatment plan and recent progress notes for patterns or gaps.

Step 3: Notice Your Internal Experience

Your internal responses offer valuable clinical information.

Ask yourself:

- What emotions do I notice in myself during or after sessions?
- Am I feeling anxious, frustrated, disconnected, overly responsible, or uncertain?
- Could countertransference be present?
- Am I avoiding something difficult or moving too quickly?

These reflections are not judgments—they are data.

Step 4: Consider Clinical Adjustments

Before pushing forward, consider whether a shift may be needed.

You might explore:

- Slowing the pace of sessions
- Returning to foundational goals
- Shifting or integrating modalities
- Naming the stuckness gently with the client (when appropriate)
- Re-centering on safety, regulation, or relationship

Not all stuck places require big changes—sometimes they need space.

Step 5: Seek Consultation or Supervision

Consultation is an essential part of ethical and skillful practice.

Reach out for support when:

- The stuckness persists across sessions
- Risk feels unclear or elevated
- You feel unsure about diagnosis, direction, or level of care
- Strong emotional responses are present
- You want another perspective before making changes

Seeking consultation protects both the client and the counselor.

Step 6: Document Thoughtfully

When you feel stuck, documentation matters even more.

Ask yourself:

- Does my note reflect the complexity of what's happening?
- Have I documented my clinical reasoning and observations clearly?
- Would another clinician understand where things are and why?

Clear documentation supports continuity and ethical care.

A Gentle Reminder

Feeling stuck does not mean you are doing something wrong.

It often means you are paying attention.

Clinical work is relational, layered, and human. Curiosity, reflection, consultation, and documentation are all part of doing this work well—and you do not have to hold it alone.

Risk Assessment Support

Beyond the Mirror Counseling & Wellness

Assessing risk is a core responsibility of clinical work. It is not about predicting outcomes—it is about slowing down, asking clear questions, and documenting thoughtfully to support safety, ethical care, and continuity.

This guide is designed to support you when risk feels present, unclear, or shifts over time.

Step 1: Pause and Assess the Moment

When risk comes up, the first task is to slow the session down.

Ask yourself:

- What prompted concern right now?
- Is this new information, a shift in presentation, or a pattern over time?

- Does this feel acute, chronic, or situational?

Risk assessment begins with presence, not urgency.

Step 2: Ask Direct, Clear Questions

Clear questions create safety. Asking directly does not increase risk.

Assess for:

- Suicidal ideation (current or historical)
- Intent
- Plan
- Means
- Self-harm behaviors
- Homicidal ideation (if indicated)

Use straightforward language and document responses clearly.

Step 3: Explore Context and History

Risk does not exist in isolation.

Consider:

- History of suicidal ideation or attempts
- Recent losses, transitions, or stressors

- Substance use
- Trauma history
- Previous hospitalizations or higher levels of care

Past experiences inform present risk.

Step 4: Identify Protective Factors

Protective factors help contextualize risk and support safety planning.

Explore:

- Relationships and social support
- Reasons for living
- Coping skills
- Engagement in treatment
- Values, responsibilities, or future orientation

Protective factors should be specific, not assumed.

Step 5: Determine Current Level of Risk

Based on what you've gathered, ask yourself:

- Does risk appear low, moderate, or high?
- Has risk increased, decreased, or remained stable?

- Can this risk be managed at the outpatient level?

When risk feels unclear, consult.

Step 6: Take Appropriate Action

Depending on the level of risk, next steps may include:

- Creating or reviewing a safety plan
- Increasing session frequency
- Coordinating with supports or providers
- Consulting with supervision
- Exploring a higher level of care

You do not need to hold these decisions alone.

Step 7: Document Clearly and Thoroughly

Documentation is a critical part of risk assessment.

Ensure notes include:

- What was asked
- What the client reported
- Clinical observations
- Protective factors

- Clinical judgment and next steps

Clear documentation protects the client and the counselor.

When to Seek Consultation Immediately

Consult supervision or clinical leadership when:

- Risk feels elevated or unclear
- A client reports intent or plan
- You feel unsure about next steps
- You notice strong emotional reactions in yourself
- You are considering a higher level of care

Consultation is part of ethical practice—not a sign of inexperience.

A Gentle Reminder

Risk assessment is not about getting it perfect.

It is about being present, thorough, and thoughtful.

Asking hard questions, documenting clearly, and seeking support are all signs of strong clinical care.

When to Seek Consultation or Supervision

Beyond the Mirror Counseling & Wellness

Consultation and supervision are essential parts of ethical, skillful clinical work. They are not indicators of weakness or inexperience—they are indicators of care, responsibility, and professionalism.

This guide is here to help you recognize when reaching out for support is both appropriate and necessary.

Step 1: Notice Internal Signals

Your internal experience often provides the first clue that consultation may be helpful.

Consider consultation when you notice:

- Feeling stuck over multiple sessions
- Uncertainty about direction or next steps
- Strong emotional reactions to a client
- Feeling overly responsible for outcomes
- Avoidance or dread before sessions

These signals are information, not failures.

Step 2: Look for Clinical Indicators

Certain clinical situations warrant consultation due to complexity or risk.

Seek consultation when:

- Risk feels unclear, elevated, or shifts suddenly
- Progress has stalled despite consistent intervention
- Diagnosis feels uncertain or complicated

- Boundaries feel blurred or strained
- The therapeutic relationship feels strained or stuck

Complexity deserves support.

Step 3: Consider System and Scope Factors

Consultation is especially important when questions arise about scope or systems.

Reach out when:

- You are unsure whether outpatient care is sufficient
- A higher level of care may be indicated
- Coordination with other providers is needed
- Ethical or legal questions emerge

These decisions should never be made in isolation.

Step 4: Use Consultation Thoughtfully

When seeking consultation, it can be helpful to clarify:

- What feels unclear or concerning
- What you've already tried
- What questions you're holding
- What kind of feedback or support you're seeking

Consultation works best when it's intentional and collaborative.

Step 5: Document Consultation and Clinical Reasoning

Documentation should reflect that consultation occurred when clinically relevant.

Include:

- That consultation or supervision was sought
- The general focus of the discussion
- How it informed clinical decision-making

Clear documentation supports continuity and ethical care.

When to Seek Immediate Support

Reach out to supervision or clinical leadership promptly when:

- A client reports suicidal intent or plan
- Risk escalates or feels difficult to manage
- You are unsure about safety or next steps
- You feel emotionally overwhelmed or frozen

You are not expected to hold these moments alone.

A Gentle Reminder

Good clinicians seek consultation.

Experienced clinicians seek consultation.

Ethical clinicians seek consultation.

Reaching out is not a disruption to the work—it is part of the work.

Diagnostic Clarity

Beyond the Mirror Counseling & Wellness

Diagnosis is not about labeling—it is about making sense of what the client is experiencing in a way that supports ethical care, appropriate treatment, and continuity. Diagnostic clarity develops over time and often evolves as therapy unfolds.

This guide is here to support thoughtful, grounded diagnostic decision-making.

Step 1: Start With the Client's Experience

Begin with what the client is actually living, not the diagnosis itself.

Ask yourself:

- What symptoms is the client reporting?
- How long have these symptoms been present?
- How do symptoms impact daily functioning, relationships, or work?
- What feels most distressing or impairing to the client?

Diagnosis should emerge from the story, not be imposed on it.

Step 2: Assess Functional Impact

Diagnosis is supported by impairment, not just symptom presence.

Consider:

- Does this interfere with work, school, relationships, or self-care?
- Is distress persistent, episodic, or situational?
- Has functioning changed over time?

Functional impact strengthens diagnostic justification.

Step 3: Review Diagnostic Criteria Thoughtfully

Use diagnostic criteria as a guide, not a checklist.

Ask yourself:

- Do the reported symptoms align with diagnostic criteria?
- Are duration and severity consistent with the diagnosis?
- Are there alternative diagnoses that should be ruled out?

When multiple diagnoses seem possible, consultation is encouraged.

Step 4: Rule Out Other Factors

Pause to consider other explanations before finalizing a diagnosis.

Reflect on:

- Trauma history
- Substance use

- Medical or neurological factors
- Developmental context
- Environmental or situational stressors

Misdiagnosis often happens when context is overlooked.

Step 5: Use the Client's Voice

Including client quotes strengthens diagnostic clarity and documentation.

Consider:

- What language does the client use to describe their experience?
- How do their words illustrate symptoms or impairment?

Example:

- Client reports, "I'm constantly on edge and can't relax," supporting anxiety-related symptoms.

Quotes ground diagnosis in lived experience.

Step 6: Allow Diagnosis to Evolve

Initial diagnoses are often provisional.

Ask yourself:

- Does the diagnosis still fit as therapy progresses?

- Has new information emerged?
- Is an adjustment clinically appropriate?

Updating a diagnosis is a sign of attentiveness, not error.

Step 7: Consult When Uncertain

Consultation is recommended when:

- Multiple diagnoses feel possible
- Symptoms overlap significantly
- Risk factors are present
- You feel unsure about justification

Diagnostic decisions do not need to be made alone.

Step 8: Document Clinical Reasoning

Documentation should reflect how you arrived at the diagnosis.

Include:

- Symptom presentation
- Functional impact
- Client quotes
- Rationale for chosen diagnosis

Clear documentation protects the client and the counselor.

A Gentle Reminder

Diagnosis is a tool, not a verdict.

It serves treatment, safety, and continuity—not perfection.

Thoughtful diagnosis grows from curiosity, reflection, and consultation.

Clinical Decision Aid

Treatment Plan Alignment

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A treatment plan is not meant to sit on a shelf. It should reflect the actual work happening in therapy and evolve as the client grows. When treatment feels unclear or documentation feels disconnected, alignment is often the missing piece.

This guide supports you in checking whether treatment goals, objectives, and interventions are working together.

Step 1: Revisit the Presenting Concerns

Start by grounding yourself in why the client came to therapy.

Ask yourself:

- Do the current goals still reflect the client's primary concerns?
- Has the focus of therapy shifted since the treatment plan was created?
- Are we working on what feels most relevant to the client right now?

If the work has changed, the plan should change too.

Step 2: Review Goals and Objectives

Treatment goals should provide direction. Objectives should show movement.

Ask yourself:

- Are the goals broad but meaningful?
- Are objectives specific and measurable?
- Would someone unfamiliar with the case understand what progress looks like?

If objectives feel vague, they may need to be clarified or rewritten.

Step 3: Check Intervention Alignment

Interventions should clearly support the stated goals.

Reflect on:

- Do the techniques used in session match the goals and objectives?
- Am I using interventions intentionally or out of habit?
- Is the modality appropriate for the client's needs and stage of treatment?

When interventions drift, treatment can feel scattered.

Step 4: Look at Progress Over Time

Alignment becomes clearer when viewed across sessions.

Ask yourself:

- Is progress being documented consistently?
- Are progress notes reflecting movement toward objectives?
- Has progress stalled or plateaued?

If progress has stalled, consider whether goals, objectives, or interventions need adjustment.

Step 5: Involve the Client

Treatment planning is collaborative.

Consider:

- Does the client understand the goals of therapy?
- Have goals been discussed or revisited together?
- Does the client feel aligned with the direction of treatment?

Alignment improves when the client feels included.

Step 6: Adjust When Needed

Updating a treatment plan is a sign of attentiveness, not failure.

Adjust the plan when:

- New information emerges
- Symptoms shift
- Goals are met

- New goals become more relevant

Treatment plans are living documents.

Step 7: Document Thoughtfully

Documentation should reflect alignment.

Ask yourself:

- Do progress notes support the treatment goals?
- Is it clear how sessions connect to objectives?
- Would another clinician understand the treatment direction?

Clear documentation supports continuity and ethical care.

When to Seek Consultation

Consult when:

- Goals feel unclear or misaligned
- Progress has stalled despite consistent effort
- You feel uncertain about treatment direction
- Complexity increases

Consultation strengthens alignment.

A Gentle Reminder

Alignment is not about perfection.

It's about coherence, intention, and responsiveness.

When goals, objectives, interventions, and documentation align, therapy feels steadier—for both the client and the clinician.

Documentation Support

Beyond the Mirror Counseling & Wellness

Documentation is an essential part of ethical, effective clinical care. It tells the story of the work, supports continuity, protects both the client and the counselor, and provides the clinical justification insurance companies require to cover services. Documentation is not separate from therapy—it is part of how therapy is held, supported, and sustained beyond the room.

This guide is designed to support you when documentation feels confusing, burdensome, or disconnected from the work you're doing.

Step 1: Remember the Purpose of Documentation

Before writing, reconnect with why we document.

Documentation:

- Protects the client
- Protects the clinician
- Supports continuity of care
- Communicates clinical reasoning
- Demonstrates medical necessity for insurance coverage
- Reflects ethical practice

Clear documentation helps ensure that clients can continue receiving care without disruption.

Step 2: Capture the Clinical Story

A strong note answers this question:

What happened, why did it matter clinically, and why was therapy necessary?

Ask yourself:

- What did the client bring into session?
- How did symptoms impact functioning?
- How did I respond skillfully as a clinician?
- How does this session connect to treatment goals?

Insurance reviewers need to see clinical relevance, not just conversation.

Step 3: Balance Brevity and Clinical Necessity

Notes should be concise, clinically relevant, and defensible.

Aim to include:

- Client experience and symptoms (subjective)
- Clinician observations (objective)
- Interventions used
- Assessment of progress or barriers
- Plan and next steps

Avoid:

- Casual or conversational language
- Overly vague statements
- Missing links between symptoms and intervention

Clarity supports coverage.

Step 4: Document Medical Necessity

Insurance requires documentation that therapy is necessary, not optional.

Ask yourself:

- Does this note show that symptoms impair functioning?
- Is it clear why treatment is needed at this time?
- Is progress, lack of progress, or ongoing need clearly documented?

Even when clients are doing well, documentation should reflect ongoing clinical need.

Step 5: Document Risk Thoughtfully

When risk is present or discussed:

- Document what was asked
- Document what the client reported
- Note observations and protective factors

- Document clinical judgment and next steps

Clear risk documentation supports safety and justifies level of care.

Step 6: Let Documentation Support Consultation and Coverage

Documentation should support:

- Supervision and consultation
- Continuity if another clinician becomes involved
- Insurance audits or reviews

Ask yourself:

- Would this note explain the case clearly to a supervisor?
- Would it demonstrate appropriate care to an insurance reviewer?

Good documentation serves multiple audiences.

Step 7: Check Alignment Before Finalizing

Before signing your note, ask:

- Does this support the treatment plan?
- Does it clearly justify the service provided?

- Would it make sense to someone outside the session?

Misalignment often shows up first in documentation.

A Gentle Reminder

Documentation is not about pleasing insurance companies—it is about protecting access to care.

Clear, thoughtful notes help ensure that clients can continue receiving the support they need, while also protecting you as a clinician.

When documentation feels hard, slow down, consult, and remember:

Clear documentation is an act of care—for the client, the clinician, and the work itself.

Level of Care Consideration

Beyond the Mirror Counseling & Wellness

Determining the appropriate level of care is a core clinical responsibility grounded in safety, effectiveness, and ethical practice. It is not a reflection of failure—by the client or the clinician—but a reflection of clinical attentiveness and care.

This guide is designed to help you assess when outpatient therapy is appropriate and when additional or different levels of care should be considered, including specific considerations for Eating Disorders and Addiction.

Step 1: Ground in the Current Clinical Picture

Begin with what is happening right now, not what you hope will change.

Ask yourself:

- How is the client functioning emotionally, behaviorally, and relationally?

- Are symptoms improving, stable, worsening, or fluctuating?
- Is the client able to engage meaningfully in outpatient therapy?

Level-of-care decisions should be based on current functioning, not intention alone.

Step 2: Assess Safety and Stability

Safety is always the primary consideration.

Consider:

- Presence of suicidal ideation, intent, or plan
- Self-harm behaviors or escalating risk
- Ability to regulate emotions and use coping skills
- Impulsivity, dissociation, or loss of control

If safety cannot be reasonably supported in outpatient care, consultation is required.

Step 3: Evaluate Impact on Daily Functioning

Level of care is influenced by how symptoms affect daily life.

Ask yourself:

- Is the client able to attend work, school, or caregiving responsibilities?
- Are relationships significantly impaired?
- Is the client able to complete basic self-care?

- Is substance use or disordered eating interfering with stability?

Significant impairment may indicate a need for more structure or support.

Step 4: Consider Treatment Response Over Time

Progress—or lack of progress—is important clinical information.

Reflect on:

- Has there been meaningful progress with consistent outpatient care?
- Has progress stalled despite appropriate interventions?
- Are goals realistic at the current level of care?

Stalled progress does not mean failure. It often means the level of care needs to shift.

Step 5: Eating Disorder–Specific Considerations

When working with eating disorders, level-of-care decisions often need to be made earlier and more proactively due to medical risk and symptom minimization.

Consider additional or higher levels of care when you notice:

- Ongoing restriction, bingeing, purging, or compensatory behaviors
- Significant weight changes or medical instability
- Obsessional thoughts about food, weight, body, or exercise dominating daily life
- Inability or unwillingness to follow meal support recommendations
- Increased rigidity, secrecy, or minimization of behaviors

- Escalation of behaviors during stress or transition

Eating disorders often worsen quietly. Clinical observation and documentation matter.

Step 6: Addiction-Specific Considerations

When working with addiction, outpatient therapy alone may not provide sufficient structure.

Consider additional support when you observe:

- Continued substance use despite stated goals
- Escalation of use during emotional distress or conflict
- Minimization, secrecy, or ambivalence about use
- Repeated relapse without adequate support
- Withdrawal risk or safety concerns
- Difficulty using coping skills without substances

Addiction often involves ambivalence, not lack of motivation.

Step 7: Assess Support Systems and Resources

External support matters.

Consider:

- Access to supportive relationships
- Housing stability

- Ability to attend sessions consistently
- Willingness and capacity to engage in treatment recommendations

Limited support increases the need for layered or structured care.

Step 8: Consult Before Making Level-of-Care Changes

Level-of-care decisions should not be made alone.

Consult supervision or clinical leadership when:

- Risk feels unclear or elevated
- You are considering IOP, PHP, residential, or inpatient care
- ED or addiction behaviors persist despite outpatient support
- You feel uncertain about next steps

Consultation protects both the client and the clinician.

Step 9: Discuss Level of Care Transparently With the Client

When appropriate, involve the client in the conversation.

Best practices include:

- Framing higher levels of care as additional support, not punishment
- Explaining clinical reasoning clearly and compassionately
- Addressing fears or misconceptions

- Collaborating on next steps when possible

Transparency builds trust—even in hard conversations.

Step 10: Document Clinical Reasoning Clearly

Documentation should reflect:

- Current symptoms and behaviors
- Functional impact and safety concerns
- Clinical rationale for level-of-care recommendations
- Consultation sought
- Client response to recommendations

Clear documentation supports ethical care, continuity, and insurance coverage.

A Gentle Reminder

Recommending a different level of care is an act of care, not abandonment.

Eating disorders and addiction often require more support, not more effort.

You are not responsible for holding what exceeds the limits of outpatient care.

Appropriate level-of-care decisions protect:

- Client safety
- Treatment effectiveness

- Ethical practice
- Clinical integrity