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A Helping Guide for Lay Counselors and Paraprofessionals in Therapeutic Communities

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Abstract— A rehabilitation facility utilizing the Therapeutic Community (TC) modality identified a need to improve the psychosocial support provided by its lay counselors and paraprofessional case managers. A training needs analysis (TNA) revealed significant gaps in basic counseling skills, particularly in demonstrating empathy, warmth, and respect, in addition to managing dual relationships that arise from simultaneously serving as authority figures and counselors within the program. This capstone project addresses these concerns by developing a training program grounded in Robert Carkhuff's Helping Model and Frederic Reamer's guidelines for boundary management in dual relationships.

A mixed-methods approach was used to gather data through client satisfaction surveys and focus group discussions with the case managers. Findings showed that initial rapport was easily formed due to shared lived experiences, however, sustaining a therapeutic partnership proved to be challenging due to the conflicting roles inherent in the organization. To address these concerns, a comprehensive training design was developed, incorporating lectures, role-playing exercises, and peer feedback to strengthen facilitation-phase helping skills and boundary-setting practices.

The program's goal is to equip lay counselors and paraprofessionals with the necessary skills to conduct effective and ethical counseling sessions, and to navigate the complexities of dual relationships in a TC setting. An evaluation plan which involves post-training client feedback and peer assessments is proposed to measure the program's impact. By addressing the specific developmental needs of non-professionally trained counselors, this project contributes to improving the quality of psychosocial support and aligns with broader goals of holistic, client-centered care in rehabilitation settings.

Keywords— helping skills, lay counsellors, program development, therapeutic community.

I. INTRODUCTION

Company Overview

Roads and Bridges to Recovery is a drug treatment center and behavioral modification program that operates under the Therapeutic Community (TC) modality. According to their handbook, their mission and vision is to be a leader in setting the standard in the provision of substance abuse treatment and behavioral modification services in the country; to provide services that fully understand and adequately respond to the biopsychosociospiritual needs of their recovering clients and their families; to provide services that address the needs of problematic non-substance induced behaviors, training activities and programs for related workers, clients, families, and

community; to provide an environment conducive to sobriety and upholds high level of values and advocacy for substance abuse prevention.

The company's mission and vision translate into providing better patient care in terms of the physical, mental, psychological, and spiritual needs of their clients. They also strive to maintain excellence by developing the skills of their employees to better serve the community.

Project Rationale

To stay true to their mission and vision, the facility sought help to improve the competencies of their staff. Specifically, in this project, a skills training program will be created for the lay counselors of the facility in order for them to provide better psychosocial support for their clients.

In a TC, the staff are a mix of professionals, paraprofessionals, and nonprofessionals, some of whom are also in recovery and are labelled lay counselors. Regardless of background, the collective role of the staff is to be "rational authorities, facilitators, and guides in the self-help community method" (Ries, Ries, Miller, Saitz, & Fiellin, 2014). As part of the TC, the staff are engaged in a helping relationship with the residents. In order to create a more solid foundation of this helping relationship, the fafcility assigns each resident their own case manager from the same pool of staff in order to provide one-on-one psychosocial support to make sure that each resident's journey is individualized to match specific needs (M. Tumanguil, personal communication, October 15, 2020). The case managers also expected to be of guidance in building the patient's insights.

In the facility, there are 4 levels in hierarchy of lay counselors: Staff, Senior, Assistant Director, and Director, all under the supervision of a Facility Director. The staff are classified into two kinds: Program and Clinical. The Program staff, who are also the lay counselors, are previous residents of the facility who graduated from their rehabilitation program and chose to work in the facility to give back and maintain their sobriety. According to Lewin, et al. (2005), lay counselors are individuals with no professional training, paraprofessional certification, nor have finished tertiary education, who carry out functions that are related to health care. The Clinical staff, on the other hand, hold psychology degrees and may or may not be licensed professionals, and as such can be paraprofessionals or professionals. All staff can be assigned caseloads (M. Tumanguil, personal communication, October 15, 2020). In essence, a case manager can be either a lay counselor, a paraprofessional, or a professional.

Mental Health Facilitator Program

In a study done by Tan & Scalise (2016), evidence shows that lay counselors can make significant positive changes in the lives of children, adolescents, adults, couples, families, and communities. Carson (2017) says that lay counselors who are adequately trained, regardless of geography and educational attainment are often able to see things through their own cultural lenses and adapt to the needs of their clients to make them more relatable. One program that has proved to be effective and beneficial for the training of lay counselors is the Mental Health Facilitator (MHF) Program created by the National Board for Certified Counselors. The MHF program focuses on teaching basic counseling skills to community-based helpers in order to provide mental health assistance – particularly identify problems, provide initial support and problem-solving techniques to those who need it, and

learn to refer people who need continued support – in areas that have limited mental health resources. The program offers 4 curricula, namely:

1. Mental Health Facilitator: curriculum designed for use in the general population
2. MHF-ASAP!: abridged curriculum for the general population
3. MHF-Educator's Edition: curriculum designated for the unique needs of educators and school staff
4. MHF-Express Educator's Edition: condensed curriculum for educators and school staff" (Mental Health Facilitator Program Summary, n.d.)

In an study done by Carson (2017), he notes that the MHF is a 30-hour training program which includes "a basic structure for teaching helping skills, working with integrity, diversity awareness, suicide prevention, trauma response" and allows for adjustments as needed to ensure cultural appropriateness. The basic curriculum include "helping skills, mental disorders, trauma and disaster response, community services, triage and suicide, and referral to mental health providers." Mental health experts who are trained in the curriculum would go to communities to conduct trainings for other trainers, who then can get MHF-certified, and can then, in turn, train other trainers to also conduct trainings or become direct providers in the community.

Lack of Skills Training

The lack of background of many of the staff in providing psychosocial support is seen as a factor in which further training is needed. In particular, non-judgmental attitude, and warmth and empathy are competencies pointed out by supervisors that need to be improved (M. Tumanguil, A. Pabandero, K. Tomol, personal communication, October 15, 2020).

Training Needs Analysis

In response to the above concerns, the facility conducted an initial Training Needs Analysis (TNA) using a Client-Counselor Feedback form (See Appendix C) for the residents of the facility and a focus group discussion was conducted with the case managers. The feedback form was used to assess how the residents felt about their one-on-one sessions with their respective case managers. A Likert scale was used to determine their working relationship. This was accomplished by a group of sixty (60) residents of the facility. Moreover, a focus group discussion was conducted to eighteen (18) case managers to determine their feedback and perception in terms of providing psychosocial support to their respective patients and to discuss the qualities that they feel they need to improve. Their supervisors were also asked about what teaching approach the group would best respond to in terms of further training.

The initial TNA results showed that the case managers scored lowest on the items on warmth and empathy. The focus group discussion findings further revealed that case managers felt that they lacked overall training in counseling methods. The case managers also identified dimensions that they would most want to improve on which are empathy, warmth and respect. Moreover, the training modalities that were identified to be most effective included lectures and practical workshops for application. Finally, the case managers scored an average of 8 out of 10 on the addiction questionnaire, which shows that they have the basic knowledge on addiction and will not need additional seminars on the topic.

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Project Objectives

Given the results and the results of the initial TNA, this project aims to 1) conduct a further needs analysis that will determine what competencies the staff of the facility need to learn, 2) develop a helping skills competency training program to address the needs of the staff and meet the mission and vision of the company to adequately respond to the biopsychosociospiritual needs of their recovering patients and their families, and address the needs of problematic non-substance induced behaviors, and, finally, 3) recommend an evaluation plan.

III. METHOD

This investigator conducted a TNA based on Carkhuff's framework on helping relationships. A mixed-methods approach was used to gather data which would form the basis of the training program.

Participants

The participants for the training are eighteen (18) case managers of the facility, eight of which are from Manila branch, and ten of which are from Cebu Branch. This includes seven (7) males and eleven (11) females with ages ranging from twenty-one (12) to fifty-one (51).

For the training needs analysis, at least sixty (60) in-patient clients were asked to evaluate the helping competencies of their case managers in a survey questionnaire. Additionally, two groups participated in a focus group discussion. The first group consisted of the case managers from the facility in Manila, and the second group consisted of the case managers from the facility in Cebu. Each group was also asked to answer a 10-item questionnaire to evaluate their basic knowledge on addiction.

Measures

The survey for the in-patient clients is answerable with a 5-point Likert scale (see Appendix C) with items such as "my shows me genuine concern and honesty" and "my counselor understands things from my point of view". In turn, a focus group discussion guide was used to collect appropriate data (see Appendix B). The focus groups for the case managers tackled the case managers' self and peer evaluations and possible training approaches that they feel would be most beneficial for them. The results of the survey that was taken by the clients was also discussed. The objective of the focus group discussion is to identify the following:

- Counseling skills that need to be improved as evaluated by the counselors themselves.
- Counseling skills that need to be improved according to the survey results accomplished by the clients.
- Training modality that would be most effective for the target group.

Questions such as "what skills do you think you need to work on in terms of counseling?" and "what type of teaching method do you think you would be most effective for you in terms of developing your counseling skills?" were asked during the focus group. Finally, the 10-item addiction questionnaire containing 4 True or False items and 6 multiple choice items with questions such as the following was given to the case managers to gauge their basic understanding on addiction:

__ A symptom of addiction is extreme mood changes. T or F?

Addiction is considered:

A. Mental Illness
B. Brain disease
C. Healthy
D. A and B
E. B and C

Data Gathering Procedure

The selection of survey respondents and FGD participants was done through purposive sampling. The survey was conducted inside the facility. The FGD for the case managers of the Manila branch was be done in-person, while the FGD for the case managers of the Cebu branch was done via a Zoom meeting. The participants were given a consent form (Appendix B) before beginning the discussion and a guide (Appendix A) was used to facilitate the session. The discussion was recorded.

Data Analysis Procedure

Quantitative. A descriptive analysis was done in order to summarize the data from the survey. Each point on the 5-point Likert scale have the following equivalent: 1 – strongly disagree, 2 – disagree, 3 – neutral, 4 – agree, 5 – strongly agree. The scores from each item was encoded on MS Excel and the mean was computed for each item. A mean closer to 1 was interpreted as low, while a mean closer to 5 was interpreted as high. The items with the lowest means determined which counseling skills will be prioritized in the training program.

Qualitative. Thematic analysis was done in order to determine the dominant patterns that came up during the FGD. The six steps developed by Braun and Calrke (2006) was used for the analysis. As shown in Figure 1, (1) The data was first transcribed and an initial overview was taken. (2) They data was then coded to describe its contents, after which, (3) themes and patterns were identified. (4) Once the themes have been identified, they were reviewed and finalized. (5) The final themes were then defined and put in order for them to be easily understandable. (6) Finally, the analysis of the data was written up.

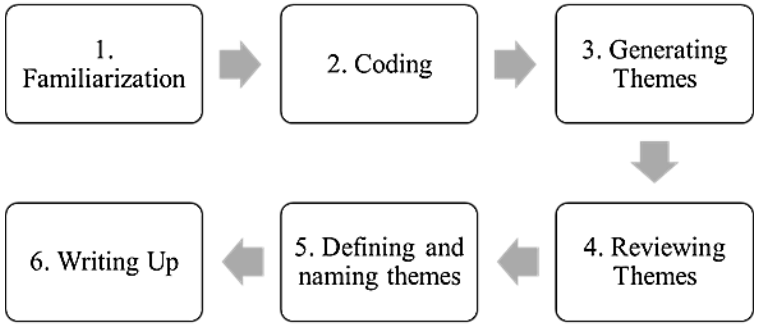

Figure 1: The six steps of thematic analysis developed by Braun and Clarke (2006)

Ethical Considerations

The study was conducted in accordance with ethical standards. Formal approval was obtained from the participating institution before the study commenced. Participants were informed about the study's objectives, as

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well as its potential risks and benefits. They were also made aware of their right to opt out and withdraw from the study at any time without any penalty.

III. FINDINGS

Training Needs Analysis

The trainees and case managers of the facility were asked to participate in a training needs analysis. The trainees were asked to answer an evaluation of each of their case managers' counseling skills. The results showed that the case managers scored lowest on the items on warmth and empathy.

In turn, an FGD was conducted with the case managers of the facility wherein they were asked to identify dimensions in counseling that they felt they wanted to improve on. The results of the group discussion showed that they would most want to improve on empathy, warmth, and respect. One mentioned "Siguro empathy and warmth.. kasi with our modality na therapeutic community, sa tingin ko nakakalimutan na minsan na kailangan pala magpakita ng warmth, especially sa caseloads ko". They also scored an average of 8 out of 10 on the addiction questionnaire, which shows that the case managers of the facility have basic knowledge on addiction. Furthermore, the case managers agreed that the most effective way for them to learn and improve their counseling skills is through lectures and practical workshops.

The following themes emerged from the focus group discussion:

Establishing rapport is easy

It was a common sentiment among the case managers that establishing rapport with their case loads is something that they can easily do. One states "madali lang mag-establish ng rapport with my caseloads kasi familiar ako sa case nila and pinaparamdam ko na magkakampi kami". Another says that "tingin ko madali din para sa akin kasi alam nila na yung mga naranasan nila, naranasan ko din noon so gumagaan ang loob nila sa akin knowing that".

Maintaining rapport is challenging because of the nature of the therapeutic community program

According to the case managers, maintaining rapport becomes difficult especially when they have to implement the therapeutic community program, which requires for them impose authority on the trainees. One says "kapag nasa program kasi, siyempre strict tayo sa lahat. And mas mahaba yung time na nasa pogram tayo compared sa counseling. Kaya minsan kapag oras na para mag counseling, nadadala yung pagkastrict natin. Eventually, nag-aalangan tuloy silang mag open up sa atin ". Another affirms, saying "I feel that sometimes, they don't trust us enough to actually tell us how they are feeling kasi sa program mahigpit diba".

It is difficult to show empathy, warmth, and respect while in the program

According to majority of the case managers, it is difficult to show warmth towards their caseloads, again, because of the nature of the therapeutic community, wherein part of their role is to show authority. "Ang hirap mag show ng warmth kasi sanay tayo na sobrang strict and confrontational sakanila. We expedite and we put pressure.. eh parang ang hirap naman maging warm while doing that". "Ang hirap din mag switch ng mood na authoritarian tapos biglang approachable.. parang ang plastic ng dating".

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Proposed Training Design

The results of the TNA showed that the case managers have a basic understanding of what addiction is. They are also aware that establishing rapport is easily done, especially in the beginning of the therapeutic relationship with their caseloads. However, as the trainee's program advances, it becomes more difficult to maintain rapport because of the authoritarian nature of the therapeutic community – that is, it is hard for the case managers to show warmth and respect during counseling sessions when most of the time, they are exercising strict authority over them outside of their counseling sessions. Furthermore, the case managers voiced out challenges in switching between their roles as authority figures and case managers.

Given the results of the TNA, the content of the training program will revolve around the key concepts of Carkhuff's helping model (please see Table 1), particularly, the dimensions of the phases. It focuses on the dimensions needed in the different phases of the helping relationship. Being able to learn and develop these dimensions, a lay counselor will be able to effectively facilitate their involvement in the helping process (Aspy, 1986). Additionally, a course on boundary setting in dual relationships will be added to the program to address the case managers' concerns. To evaluate the effectiveness of the training, practical exercises will be done after each module followed by giving and receiving of feedback from their peers. A post-test will also be conducted for the clients to complete. At the same time, peer evaluation will also be done through focus group discussion. The elements to be measured are: (1) Learning, (2) Application, (3) Results. The proposed training design aims to teach the participants to:

- Identify the goals of counseling
- Determine the necessary basic helping skills
- Develop basic helping skills for facilitation
- Learn to express empathy, warmth, and respect during counseling sessions
- Gain awareness on dual relationships and its effect on therapeutic relationships
- Manage and set appropriate boundaries in relation to dual relationships

Section I - Counseling Skills

The first section of the workshop provides a theoretical basis on the concept of counseling or helping, its goals, its process or stages, and the dimensions required for each stage – focusing on the facilitation stage and its dimensions. Roleplaying will also be done in order to help the case managers practice their skills. The ultimate goal is to improve their counseling skills by strengthening their understanding on how to show empathy, warmth, and respect towards their caseloads.

This section of the training design is divided into 3 parts, each containing a lecture and a practical exercise to ensure that what is discussed translates into the case manager's helping skills. The practical exercises intend to address the TNA results where the case managers preferred to have practical application activities as a way for them to better absorb and use the skills that they will be taught in the lectures.

The first part focuses on the overview of the process and goals of helping for each stage. The idea is to help the case managers gain better perspective as to what their roles are as helpers, depending on what stage in the helping

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process their caseloads are in. It would also give them an idea about where their boundaries and limitations are in the helping relationship.

In the second part, the discussion will focus more about the Facilitation stage and the skills that the therapist needs in order to successfully realize that stage. The lecture will focus on the 3 dimensions for the facilitation stage – empathy, warmth, and respect.

To apply learnings on this part of the training, they will be doing a group role playing exercise in order to practice those 3 skills. In the activity, they will be asked to form groups of 3, taking turns in role playing as a counselor, a client, and an observer.

The counselor's task is to try to establish rapport and begin the facilitation stage of the helping process; The client's role is to choose a past concern that has already been resolved that he/she is comfortable sharing with the group; The observer's role is to take notes about how the counselor is handling the interaction. At the end of each 10-minute session, the client and the observer will be giving feedback to the counselor.

The third part of the module will tackle about other important skills that they will need to help them better express the three skills that were tackled in the second part. Perceiving and responding will be discussed first, after which, attending skills will be tackled as well as nonverbal cues. Just like the second part, the case managers will be tasked to partake in the same role-playing exercise.

The purpose of the role-playing exercise is to allow the case managers to test their practical skills, receive feedback from their peers, and evaluate what needs to be improved.

Section II - Dual Relationships

The second section of the training will begin with a brief introduction on dual relationships in the institutional setting and its effects on the therapeutic relationship. It will be followed by a sharing of current policies or boundary-setting practices in the facility. After this exercise, the proposed 9-point guideline for risk management and boundary setting in dual relationships will be discussed in detail.

The training is expected to help the case managers become more aware about their roles in the process of helping, improve their basic counseling skills, and set proper boundaries in their therapeutic relationships.

Proposed Evaluation Plan

An important part of the project is the evaluation of its impact to the trainees and case managers of the facility. The evaluation forms used for the TNA will be used as post-training evaluations to determine whether the program was effective in bringing positive change to the counseling skills and boundary-setting practices in the facility.

IV. FRAMEWORK FOR THE PROGRAM

Based on the findings, the facility's main areas of concern are improving counseling skills and managing boundaries of dual relationships. Two frameworks will form the basis of the training program in order to address these concerns.

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Counseling Skills

Carkhuff's helping model presents the core qualities/dimensions that are needed by counselors. Gazda (1995) says that Carkhuff developed a helping model where the key concepts can be found on Table 1, which include 3 phases in the process of helping: Facilitation Phase, Transition Phase, and Action Phase.

Facilitation Phase. This phase is focused on establishing a good, healthy, curious relationship between the helper and the helpee without evaluation or judgment. There are 3 dimensions to this phase: empathy, respect, and warmth (Gazda, 1995).

Empathy. Empathy is the most important aspect in the helping process. Some ways of describing empathy are "putting oneself in another person's shoes" or "seeing through the eyes of another" (Gazda, 1995). It is important for the helper to withhold judgment, and instead communicate understanding to the helpee (Lloyd & Maas, 1993). According to Chan, Berven, & Thomas (2015), this is part of the critical facilitative conditions that help establish a working alliance between client and counselor. They also add that effective demonstration of empathy will help the counselor establish rapport, relay comfort and acceptance, and indicate consideration towards the client.

Respect. According to Gazda (1995), believing that the helpee has the ability to solve their own problems. This develops as the helper gets to know the helpee more throughout their relationship. Simply showing support and commitment (Lloyd & Maas, 1993) for the helpee and allowing them to do what they can do for themselves shows respect.

Warmth. Gazda (1995) says that warmth or caring is closely related to empathy and respect. Showing concern for those we understand and believe in not just in words but also though nonverbal cues.

Transition Phase. This phase focuses on the role of the helper to facilitate self-understanding and commitment to change of the resident. The helper becomes more evaluative of the helpee's concerns while at the same time, encouraging the helpee to delve deeper into self-exploration. There are 3 dimensions to this phase:

Concreteness. The helper facilitates concreteness by being as specific as the helpee has been in identifying or labelling feelings and experiences.

Genuineness. In order for the helping relationship to work, the relationship must be genuine. This refers to the helper's ability to show genuine concern and honesty for the helpee. It is also important for the helper to give responses in a constructive manner so as still maintaining honesty, but also encouraging the helpee to reflect on the feedback (Lloyd & Maas, 1993).

Self-disclosure. This refers to the helper's sharing of their own concerns (that have been solved) that are relevant and appropriate to the helpee's problem. Self-disclosure not only gives the helpee insight on how they can possibly deal with their own concerns, but it also strengthens the bond between the helpee and helper.

Action Phase. After evaluation of the helpee's concerns, this phase is where the helper assists the helpee in making tough decisions. The helper aids the helpee to create plans and strategies for successful problem solving for the present and the future. There are 2 dimensions to this phase:

Confrontation. This refers how the helper should respond to inconsistencies between what the helpee is saying and doing.

Immediacy. "it includes 'telling it like it is' between the helper and helpee in the here and now". The proper use of immediacy by the helper will lead to the helpee's better understanding of themselves.

In addition to these phases, it should be noted that the acts of perceiving and responding are essential parts of each dimension. In order to be interpersonally effective, the helper must be able to accurately recognize the behavior of others. At the same time, being able to communicate appropriately through verbal and nonverbal response (Gazda, 1995).

As these dimensions are key components to each phase of the helping process, the training program will focus on the dimensions that were identified for each phase – empathy, respect, warmth, concreteness, genuineness, self-disclosure, confrontation, and immediacy.

Table 1. Outline of the key dimensions of a helping relationship (Gazda, 1995).

Facilitation Dimensions*	**Transition Dimensions***	**Action Dimensions***
Empathy (depth understanding)	Concreteness (ability to be specific)	Confrontation (pointing out discrepancies)
Respect (belief in)	Genuineness (honesty, realness)	Immediacy (helper and helpee telling it like it is in the "here and now")
Warmth (caring, love) (nonverbal)	Self-disclosure (ability to convey appropriately "I've been there too.")	

*Each of the eight dimensions involves the act of perceiving (becoming aware of) and the act of responding (acting on awareness).

Dual Relationship

According to Zur (2022), dual relationships are defined as any situation in psychotherapy wherein multiple roles exist between a therapist and a client. The relationship between the trainee and the case manager is one that is considered a dual relationship because of the roles that the case manager plays in the therapeutic community.

Zur (2022) says that dual relationships in institutions such as mental hospitals, military, prisons are inherent and mandatory and categorizes these relationships as Institutional Dual Relationships.

Since part of the staff's role in the facility is to administer the TC program, there has been difficulty in separating their roles of being a program staff and providing psychosocial support as case manager – particularly in their competencies as counselors. This difficulty has become a hindrance for case managers to effectively build and sustain rapport with their caseloads.

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Herlihy & Corey (1992) say that dual relationships are not always harmful, however, one thing that makes dual relationships difficult to deal with is the lack of distinct boundaries between the roles.

In a study done by Hines et al. (1998), it was suggested that it might be helpful for the clinicians to practice boundary management and the ability of the clinician to assess on a case-to-case basis whether certain situations involving the client would require boundary crossing, depending on the risk that it poses.

Reamer (2020) says that handling concerns on dual relationship and boundary management rests on the practitioner's discernment and ethical instincts, and how they make genuine and ethically sound judgements.

He additionally recommends that the following risk management guidelines should be put in place concerning dual relationships and boundary issues.

1. Setting clear-cut boundaries in the beginning of the therapeutic relationship with proper documentation.
2. Evaluate and discuss with the client possible boundary issues that may arise with consideration to the following: a) "the amount of power that the practitioner holds over the client," b) possible duration of the relationship, c) the conditions surrounding the relationship, d) risks that the relationship pose based on the client's clinical needs, e) code of ethics
3. Consider whether based on the criteria, the relationship is justifiable.
4. Be aware of potentially conflicting roles in the relationship.
5. If doubtful about the dual relationship, consult colleagues and supervisors.
6. Keep the clients fully informed about the relevant issues and inform clients of the potential risks the relationship might cause.
7. Supervision is encouraged whenever related risks are high, and an "exit strategy" and alternative plans should be put in place in situations where the dual relationship proves to be harmful.
8. Make the necessary referrals. There may be a need to refer the client to another professional in order to lessen the risk and prevent any harm.
9. Properly document every aspect of decision-making, and any actions taken in relation to the relationship.

V. CONCLUSION

This project addresses critical gaps in the counseling competencies of lay counselors and paraprofessionals in therapeutic communities.

By integrating Carkhuff's helping model and Reamer's boundary management guidelines, the proposed training program helps strengthen essential helping skills like empathy, warmth, and respect, while giving therapeutic community staff the ability to navigate the complexities of dual relationships.

Grounded in a training needs analysis and designed with practical, culturally responsive methods, the program enhances the quality of psychosocial support and aligns with the broader goal of client-centered, ethical care in the therapeutic community.

REFERENCES

[1] C. B. Aspy, "The Carkhuff models in human resource development," Education, vol. 3, pp. 252, 1986.

[2] V. Braun and V. Clarke, "Using thematic analysis in psychology," Qualitative Research in Psychology, vol. 3, no. 2, pp. 77–101, 2006. DOI: 10.1191/1478088706qp063oa.

[3] F. Chan, N. L. Berven, and K. R. Thomas, Counseling Theories and Techniques for Rehabilitation Health Professionals. New York: Springer Publishing Company, 2015.

[4] D. K. Carson, "Lay Counselor Training In Developing Countries: Needs, Approaches, and Impact on Quality of Life," The International Journal of Humanities & Social Studies, vol. 5, no. 2, pp. 82–88, 2017.

[5] G. De Leon, The Therapeutic Community: Theory, Model, and Method. New York: Springer Publishing Company, 2000.

[6] S. Dewing, C. Mathews, A. Cloete, N. Schaay, L. Simbayi, and J. Louw, "Lay counselors' ability to deliver counseling for behavior change," Journal of Consulting and Clinical Psychology, vol. 82, no. 1, pp. 19–29, 2014. DOI: 10.1037/a0034659.

[7] G. M. Gazda, Human Relations Development: A Manual for Educators, 5th ed. Needham Heights, MA: Allyn & Bacon, 1995.

[8] B. Herlihy and G. Corey, Dual Relationships in Counseling. Alexandria, VA: American Association for Counseling and Development, 1992.

[9] C. E. Hill, Helping Skills: Facilitating Exploration, Insight, and Action. Washington, DC: American Psychological Association, 2020.

[10] A. H. Hines, D. N. Ader, A. S. Chang, and J. R. Rundell, "Dual agency, dual relationships, boundary crossings, and associated boundary violations: A survey of military and civilian psychiatrists," Military Medicine, vol. 163, no. 12, pp. 826–833, 1998. URL: https://www.proquest.com/scholarly-journals/dual-agency-relationships-boundary-crossings/docview/217044331/se-2.

[11] S. Lewin et al., "Lay health workers in primary and community health care," Cochrane Database of Systematic Reviews, 2005. DOI: 10.1002/14651858.cd004015.pub2.

[12] C. Lloyd and F. Maas, "The Helping Relationship: The Application of Carkhuff's Model," Canadian Journal of Occupational Therapy, vol. 60, no. 2, pp. 83–89, 1993. DOI: 10.1177/000841749306000205.

[13] M. Luke, J. S. Hinkle, W. Schweiger, and D. Henderson, "Mental Health Facilitator (MHF) Service Implementation in Schools in Malawi, Africa: A Strategy for Increasing Community Human Resources," The Professional Counselor, vol. 6, no. 1, pp. 1–21, 2016. DOI: 10.15241/ml.6.1.1.

[14] L. Magor-Blatch, "An Introduction to the Therapeutic Community," ATCA, Sep. 2009. URL: http://www.atca.com.au/wp-content/uploads/2012/09/Lynne-Magor-Blatch-TC-Workshop.pdf.

[15] Mental Health Facilitator Program, n.d. Retrieved Oct. 24, 2020. URL: https://www.mentalhealthfacilitator.org/.

[16] Mental Health Facilitator (MHF) Curricula, n.d. Retrieved Nov. 12, 2020. URL: https://mentalhealthfacilitator.org/Program/Curricula.

[17] National Board for Certified Counselors, Inc. and Affiliates, Mental Health Facilitator Program Summary, n.d. Retrieved Mar. 1, 2022. URL: https://www.mentalhealthfacilitator.org/Program/Curricula.

Volume: 04 / Issue: 05 / 2025 - Open Access - Website: www.mijrd.com - ISSN: 2583-0406

[18] F. G. Reamer, Boundary Issues and Dual Relationships in the Human Services. New York: Columbia University Press, 2020.

[19] R. K. Ries, R. Ries, S. C. Miller, R. Saitz, and D. A. Fiellin, The ASAM Principles of Addiction Medicine. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

[20] "SELF: Where real help begins," Oct. 16, 2019. Retrieved Oct. 23, 2020. URL: http://selfoundation.com/.

[21] S. Tan and E. T. Scalise, Lay Counseling: Equipping Christians for a Helping Ministry. Grand Rapids, MI: Zondervan, 2016.

[22] Therapeutic Community Curriculum: Trainer's Manual [Electronic Resource]. Rockville, MD: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2006.

[23] U.S. Dept. of Health and Human Services, F. M. Tims, G. De Leon, and N. Jainchill, Therapeutic Community: Advances in Research & Application. Rockville, MD: U.S. Dept. of Health and Human Services, 1994.

[24] A. E. Wagener, L. K. Jones, and J. S. Hinkle, "The Mental Health Facilitator Program: A Multi-Country Evaluation of Knowledge and Skills Acquisition," The Professional Counselor, vol. 9, no. 4, pp. 324–333, 2019. DOI: 10.15241/aew.9.4.324.

[25] O. Zur, "Therapeutic Boundaries and Dual Relationships in Psychotherapy and Counseling," 2015. URL: http://www.zurinstitute.com/boundariesbrochure.pdf.

[26] O. Zur, "Dual relationships, multiple relationships, boundaries, Boundary Crossings, & boundary violations in psychotherapy, counseling & mental health," Zur Institute, 2022. Retrieved Jan. 26, 2023. URL: https://admin.zurinstitute.com/boundaries-dual-relationships/.