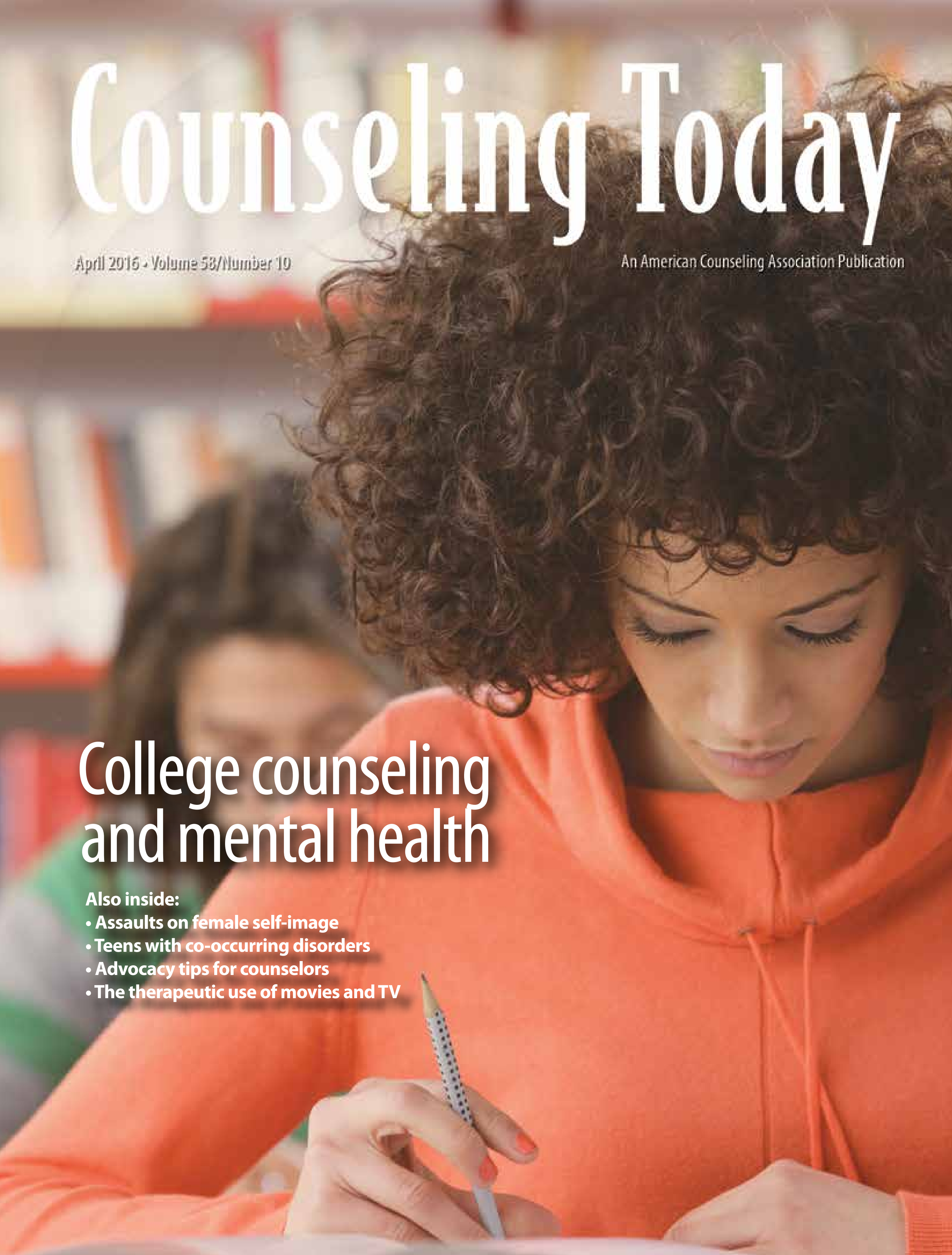
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April 2016 • Volume 58/Number 10
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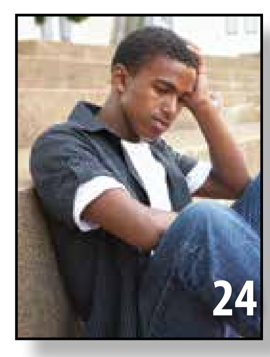

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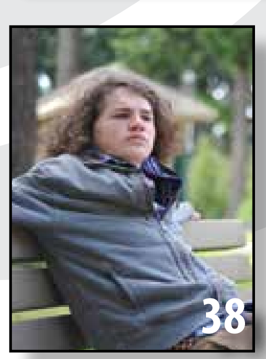

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Thelma Duffey

Impressions of a traveler

Greetings, fellow counselors! As I prepare for the American Counseling Association Conference in Montréal (being held in partnership with the Canadian Counselling and Psychotherapy Association) and reflect on what I was doing this time last year, I am amazed. What a tremendous year this continues to be. I feel such pride in our profession and have such great hopes for its future.

Counselors are doing wonderful work in the world, and I have an opportunity, through my travels, to experience some of this work firsthand. I'd like to chronicle here some of my experiences thus far in 2016 so we can celebrate and shed light on some of the great things our colleagues are doing throughout the country.

This past January was particularly cold in many parts of the country, but that wasn't the case at Rollins College in Winter Park, Florida. In fact, the sun was shining as the school's students engaged in creative learning activities in a "master therapist" series that provided cutting-edge opportunities for professional skill building. It was such an honor to spend time with these students and their amazing faculty. I left glorious Winter Park with a deep appreciation for the faculty's investment in instilling pride, confidence and a strong sense of professional identity among the students. What a terrific way to start the year.

Days later, I braved an East Coast blizzard to attend a reception at the White House to recognize the national School Counselor of the Year. Our school counselors do such important work, and to have this acknowledged by our nation's first lady, Michelle Obama, was a rich and truly memorable experience.

From there, I flew to Boise for the Idaho Counseling Association (ICA) conference. Late January brings a bit more than a chill in the air to Idaho, but the reception and camaraderie that ICA members afforded me was heartwarming, and the conference itself was action packed, productive and a whole lot of fun. ICA knocked it out of the park and held a wonderful conference.

Next stop? Dallas. I traveled to my home state of Texas, where ACA partnered with the Human Rights Campaign for this year's Time to Thrive Conference. There are few words to express the power of this experience. I left feeling deep hope for a future that includes safety, pride and connectedness for the hundreds of participating lesbian, gay, bisexual, transgender and questioning youth. I also left feeling grateful that ACA CEO Richard Yep and staff continue to find ways to promote this important ACA mission through advocacy and collaborations such as Time to Thrive.

The trip from Dallas to my hometown of San Antonio was a quick one. And that's a good thing because I was home long enough only to pack a suitcase

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Ready. Set. Connect!

As promised, we've revised ACA Connect—our dynamic online networking tool for members only—to reflect your feedback. This means simplified ways to engage, streamlined content, and much more. Let's break it down into five key points.

1. You will NOT be auto-subscribed to anything. Engage as little or as much as you like based on your current interests. No need to worry about constant communications flooding your inbox. Everything is on *your* terms.

2. You can now target your Connect posts within five topic-based communities. In the past there was one general Open Forum, which didn't provide much structure for effective communication. New topic-based communities allow you to engage *with context*, thus enabling better results. The new communities are:

- Practice
- Research
- Teaching
- Supervision
- Public Policy

Opt to receive a daily digest from the communities to which you belong, via email! Check out our new FAQs online to learn more.

3. You can still engage with popular original features, which have been improved to better serve your needs. Join an Interest Group quickly with the click of a button, and explore Libraries that have been updated with additional resources to reflect the unique needs of each community.

4. You can now refine your Connect searches by category, content type, community, and/or date. Your time is valuable. These new enhancements will help you make the most of it.

5. Everyone will benefit from the revised Rules and Etiquette page. But most important, please be kind to one another. People will always have differences in opinion, but at the end of the day, remember that we are united for the good of the counseling profession. That's a powerful thing. Let's embrace and protect it.

Still not convinced ACA Connect is worth your time? Don't take our word for it. Check out what your peers had to say…

"I've used it specifically to learn more about private practice business models as well as therapeutic approaches." Kambria Kennedy, MS, LPC, LCDC, RYT

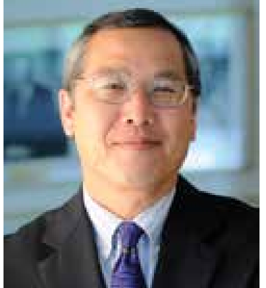
"The most important thing in our work, and life in general, is the connections we make with others. ACA Connect offers important professional connections to people, ideas, information, and inspiration." Jill Nelson, MS, LCPC

"Sometimes something will happen in my practice or with a client that will put my thoughts in 'muse' mode. It is at times like these that I enjoy ACA Connect because I often put my musings online just to see what my colleagues have to say." Michael Rockel, LMHC

"My ability to engage with all of our members and leadership teams via ACA Connect in order to view societal needs through a global lens, share opportunities, and work collaboratively is invaluable!" Chris Roseman, PhD, LPCC

"I use it to join with my colleagues on projects, to gather timely information, and to stay connected on issues related to my specialization area of addiction counseling. It is a great professional resource, I'd be lost without it!" Christine Chasek, LIMHP, LADC, LPC

Ready to Connect? Visit *community.counseling.org* to jump right in!



Richard Yep

Let's make this one all about you

You work hard, and the collective efforts of the counseling profession benefit millions of children, adolescents, adults, couples, families and communities each and every day. Although your work may not get reported on CNN or in *The New York Times*, the impact of professional counseling cannot be denied. You make the world a better place, and that is not hyperbole; it is fact.

Because of the amazing work of professional counselors, ACA set out many years ago to find a way to raise public awareness of what you do. From that desire was born Counseling Awareness Month. Please note that it is not a day or a week but an entire month! Given all there is to tell about the importance of counseling and the work of our members, we wanted a full month. We know you are busy and that you give 100 percent to your clients and students, so asking you to share your story or to support efforts to increase the public's knowledge about counseling may at first seem to be asking too much. Our hope is that you will recognize the benefit of celebrating Counseling Awareness Month, but rather than doing it alone, that groups can come together at local, state and regional levels to let the public know of your great work.

To make it easier, ACA has developed information, suggestions and tips for how you can participate in Counseling Awareness Month. Simply go to *counseling.org/about-us/counseling-awareness-month-2016* to find the special resources we have developed just for you. Over the years, many of you have established your own events to celebrate Counseling Awareness Month, and I hope even more groups of counselors will do that this year. Let's make the 2016 Counseling Awareness Month the best ever.

I realize professional counselors do not typically seek the limelight for the work they do, but please know that the ACA staff and volunteer leadership deeply appreciate the work of our members. I hope that being a member of the ACA family will come to mean more to you than just receiving *Counseling Today*, buying books that we publish, attending our conference or knowing that we advocate for the profession at the state and federal levels of government. Yes, we provide all of those things (and more), but we want ACA to be your professional home because you feel that we look out for you as a practicing professional. We provide a way for you to network and interact with your peers. We provide consultation about your career, ethics and practice issues. Our mission is to be your professional partner and a supporter of the good work you do.

We also want to be the place you turn to when communicating with your peers. You may have noticed that our online community, ACA Connect, underwent some extensive changes and was recently relaunched based on the input and comments you shared with us. Although the previous version was good and did serve as a community place where members could interact, your suggestions helped us to make some substantial improvements. This is yet another way we are trying to improve ACA as your professional home.

So, as we kick off Counseling Awareness Month, I want to personally congratulate all of you for the service you provide to so many people. When I hear stories of your work, I am in awe of what you do, and I am humbled by your efforts to advocate for and serve your clients and students. Job well done.

As always, I look forward to your comments, questions and thoughts. Feel free to call me at 800.347.6647 ext. 231 or email me at *ryep@counseling.org*. You can also follow me on Twitter: *@RichYep*.

Be well. ❖

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Counseling Today (ISSN 1078-8719) is the monthly magazine of the American Counseling Association, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22304-3300; Telephone: 703.823.9800; Internet: ct.counseling.org.

Opinions expressed in this magazine do not necessarily represent opinions of the editors or policies of the American Counseling Association.

Subscriptions are available for $150 for 12 issues.
Email: cs-journals@wiley.com
Americas: 1-800-835-6770
Europe, Middle East & Africa:
+44 (0)1865 778315
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Single copies are available for $12.50 each by calling ACA in-house fulfillment at 800.422.2648 ext. 222.

Periodicals postage paid at Alexandria, Virginia, and additional mailing offices. Postmaster: Send address changes to ACA Member Services, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22304. All rights reserved, 2016 by the American Counseling Association.

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Mission Statement
The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession and using the profession and practice of counseling to promote respect for human dignity and diversity.

Valuable insight into private practice

I recently graduated with a master's degree in counseling and am working as a provisionally licensed professional in the counseling field. I am writing because I feel compelled to tell you how much I appreciated Lynne Shallcross' article discussing private practice ("Becoming your own boss") in the February issue of *Counseling Today*.

I have started to consider private practice as a long-term goal but have not taken action on it because it is not the right time. I currently have a wonderful opportunity to learn from a group of dedicated counselors working with children with behavioral disorders. There are so many basic skills I get to perfect with knowledgeable and caring individuals. Consequently, as I think about the options, and talk about the future with my husband, I believe the article gave me valuable insight.

Rebecca J. Ristow, PLMHP
Lincoln, Nebraska
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Counseling as entertainment?

There are many opinions as to what makes a private practice successful. In my world, and in my geographic area, the bottom lines are as follows: having HMO contracts (I live in a heavily HMO-driven area) and providing professional, effective and compassionate services.

Anthony Centore seems to think that therapists should put on a dog and pony show. Although he does state that some of his suggestions are pushing the envelope in "A warning for your counseling practice: Be different or die" (Private Practice Strategies, March), he ignores how many of his suggestions potentially cheapen the practice and make it a source of entertainment as opposed to a place of change and growth.

If I walked in to my doctor's office and encountered people in their gym wear — just to respond to one of his suggestions — I would think I had mistakenly landed on *Star Trek*'s Enterprise. If I allow a client a last-minute cancellation for a personal emergency without charging him or her, I certainly expect a client to give me the same consideration, without refunding the late cancel fee. Create a coffee bar? Are we baristas, also?

I have been practicing for over 35 years and still believe that a successful practice can and should be built on having connections in the medical and insurance worlds, and that a satisfied client is the best source of additional referrals. I don't want to start competing with Starbucks, nor do I wish to create a clinic atmosphere that significantly alters the dignity of the counseling profession.

Myrna F. Solganick, M.S., LPC, LCSW
Sun Prairie, Wisconsin ❖

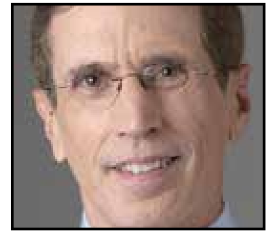
Letters policy

Counseling Today welcomes letters from ACA members; submissions from nonmembers will be published only on rare occasions. Only one letter per person per topic in each 365-day period will be printed. Letters will be published as space permits and are subject to editing for both length and clarity. Please limit letters to 400 words or less. Submissions can be sent via email or regular mail and must include the individual's full name, mailing address or email address and telephone number.

ACA has the sole right to determine if a letter will be accepted for publication. *Counseling Today* will not publish any letter that contains unprofessional, defamatory, incendiary, libelous or illegal statements or content deemed as intended to offend a person or group of people based on their race, gender, age, ethnicity, religion, sexual orientation, gender identity, disability, language, ideology, social class, occupation, appearance, mental capacity or any other distinction that might be considered by some as a liability. ACA will not print letters that include advertising or represent a copy of a letter to a third party. The editor of *Counseling Today* will have responsibility for determining if any factors are present that warrant not publishing a letter.

Email your letters to *ct@counseling.org* or write to *Counseling Today*, Letters to the Editor, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22304.

In memoriam



Craig Windham, an American Counseling Association member and newscaster for National Public Radio (NPR), died unexpectedly Feb. 28. He was 66. Windham, a licensed clinical professional counselor, was a keynote speaker at ACA's 2012 Conference & Expo in San Francisco. His voice was known to millions, as he reported and delivered the news daily on NPR's *Morning Edition* and *All Things Considered*.

To read more about Windham's life and contributions to the counseling profession, go to ACA's online In Memoriam page at *counseling.org/aca-community/in-memoriam*. ACA members are welcome to share their memories of Windham in the comments section. ❖

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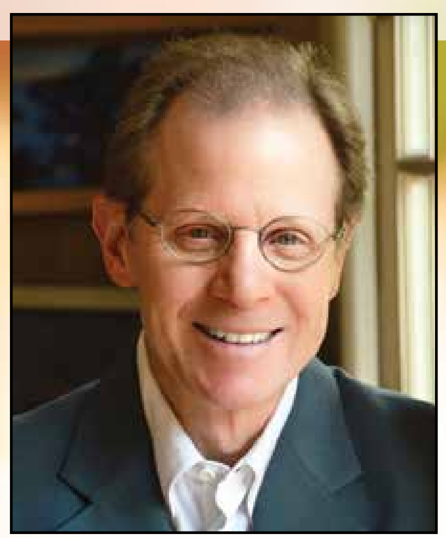

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Tennessee bill threatens counseling profession's ethics code

At the end of January, in an unprecedented turn of events, the American Counseling Association became the target of a piece of state legislation. In Tennessee, Senate Bill 1556 (and its companion bill, House Bill 1840) proposes that counselors in the state should be allowed to refer clients on the basis of a counselor's "strongly held religious beliefs."

Tennessee, like many states, adopted the *ACA Code of Ethics* into its state laws through the regulatory process overseen by the state licensing board. This bill, if passed into law, would legislate that Tennessee counselors do not have to abide by Standard A.11.b., "Values Within Termination and Referral," of the *ACA Code of Ethics*. It would also take away the authority of the state's licensing board to enforce ethics violations under this provision.

Over the past few years, a litany of so-called "right to religious freedom" amendment bills have been introduced in legislatures. These controversial bills are proffered under the protection of civil liberties, but they tread a dangerous line of legislating discrimination. In the case of the Tennessee bill, we must ask some very important questions: What does it mean to practice ethically? Where do civil liberties come into the equation? And if the bill were to become law, what is a "strongly held religious belief"?

The answers to the first two questions are quite simple. Counselors are universally taught that the needs of the client are always the top priority; it is not a question of the professional's own held beliefs and values, but those of the client. This is not a violation of civil liberties but a civic choice. When choosing to become a counselor, individuals acknowledge that it is antithetical to the profession to avoid providing help to any person regardless of "age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status or any basis proscribed by law" (*ACA Code of Ethics*, Standard C.5.). To be a counselor is to put aside one's own needs and to try to understand all individuals for who they are and where they come from.

The third question has no clear answer, and that is what ultimately makes this legislation so troublesome. Moving beyond the legislation's direct clash with the *ACA Code of Ethics*, there is no universally accepted interpretation of what a "strongly held religious belief" might be. As many have testified in House subcommittee meetings, this language could be used to deny services to lesbian, gay, bisexual and transgender (LGBT) persons and couples, interracial couples, any person of a specific ethnicity, any person holding a specific religious belief and even individuals who are divorced. Allowing licensed professional counselors (LPCs), or any health care provider, to deny services based on a "strongly held religious belief" would open Pandora's box. There is no predicting who might be denied services under those terms.

Given the nature of this bill, it may come as no surprise that it has demanded an unprecedented amount of ACA resources. The ACA Government Affairs team has been working around the clock, spending most weekdays in Nashville building the relationships needed to defeat this legislation. Lynn Linde, senior director of ACA's Center for Counseling Practice, Policy and Research, was also brought in to testify in front of the Tennessee House Health Subcommittee on Feb. 22. Equally important, counselors have been dedicating hours to efforts to defeat this legislation.

This may also represent an unprecedented example of mental health professionals joining forces to work against a bill that does not necessarily implicate their professions. Licensed marriage and family therapists have stood side by side with LPCs from Day One in opposition to this bill. Social workers, through the local National Association of Social Workers affiliate, and pastoral counselors have also joined in these efforts. Additionally, allies have joined in from patient advocate organizations such as the National Alliance on Mental Illness and LGBT and human rights groups such as the Tennessee Equality Project and the American Civil Liberties Union.

ACA and the counseling profession are very fortunate not to have been the target of destructive state legislation before now. Now more than ever, however, we must be vigilant. What happens in Tennessee will set the precedent for other states to follow suit. And even if we emerge victorious this time, additional fights will follow.

Many readers may be familiar with *Ward v. Wilbanks*, a case that involved a counseling student who did not wish to work with a client based on her personally held religious beliefs. Although that case was ultimately settled out of court, the same organization that funded that case, the Alliance Defending Freedom, is funding the efforts to pass this legislation in Tennessee.

We urge you to stay true to your profession and help us ensure that the collective memory does not forget the trials our country has gone through in years past to fight discrimination. We must remain vigilant of discrimination that still exists and continue to fight to make sure we continue to move forward rather than backward. No expense is too great if we can prevent legislating discrimination.

As this article is being written in early March, we continue to aggressively fight this bill in the Tennessee House. What is at stake goes beyond the *ACA Code of Ethics*, our association or even the counseling profession. The dignity of every person is being called into question. ❖

Kelly Nickel is the state legislative representative for the ACA Government Affairs team. Contact Government Affairs at *advocacy@counseling.org*.

Letters to the editor: *ct@counseling.org*

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What if it were 10 times more difficult to become a counselor?

Recently, I was speaking with a counselor and she said, "I schedule clients for only one session a month because I don't want them to get dependent on me."

I want to say that I was shocked, but I wasn't. Too often I hear counselors who have exceedingly poor ideas related to clinical care. I encounter counselors who can't put a treatment plan together; who don't know the diagnostic criteria for general anxiety disorder; who believe they can transfer "healing energy" from themselves to their clients; who consider "demonic influence" as a possible reason for a client's problems; who think two sessions is an effective course of brief therapy; who claim to have 15 years' experience but really have one year of experience that's been slowly forgotten over 15 years.

I believe we have a problem in our field that we don't want to talk about: Too many licensed mental health professionals lack clinical competence. Perhaps there are so many approaches to counseling and so many factions pushing the right way to work with clients that we're reluctant to call out anyone and say "that's malpractice." Also, we don't want to admit that we have fully licensed, card-carrying, inept therapists among our ranks (nor do we want someone to point their finger at us and start questioning our abilities).

Consumers aren't afraid to talk openly about this problem. Today, potential clients bounce from one counselor to the next trying to "find a good one" and share their horror stories about their experiences with therapists. This gives our profession a mixed reputation. We sometimes blame the clients for this, suggesting that their dissatisfaction with a counselor is likely a symptom of the clients' issues. I don't think so. It happens too often. For some clients, bad experiences have permanently turned them off to counseling.

What if?

What if it were more difficult to become a counselor? I'm not saying that every provider needs to offer dialectical behavior therapy or the cognitive behavioral analysis system of psychotherapy or subscribe to a certain methodology. I'm not talking about the Council for Accreditation of Counseling and Related Educational Programs or anything else so specific at this moment. I'm just asking, what if it were 10 times harder to join the ranks of counselors? Here's what it might look like:

- ❖ The licensure exam would be on par with the bar exam for attorneys or the United States Medical Licensing Examination for medical doctors. It would be exceedingly difficult.
- ❖ Providers would be retested in some way every five to 10 years.
- ❖ Continuing education requirements would be rigorous.
- ❖ Counselor education programs would be retooled so that every graduate would earn a doctorate in professional counseling, putting counselors on par academically with psychologists.
- ❖ Postdegree, prelicensure training would be reengineered so that more effective counselor preparation would take place (and so that students would have a clear path to licensure).

The result

The outcome of such significant changes would be widespread.

First, there would probably be fewer counselors because counseling would no longer be seen as an "easy" degree or career path.

Second, individuals who did prevail to earn their license would be, on average, better trained and possess a higher skill level.

Third, public esteem for counselors would improve. Counselors would be seen as extremely qualified and effective at what they do.

Fourth, supply would go down, while demand would go up. Provider compensation would be commensurate with a higher level of training and ability.

Fifth, the counseling profession would be better protected against unlicensed helping professions such as life coaches, and consumers would see greater value in licensed providers. After all, you wouldn't go to an unlicensed doctor, dentist or attorney, would you?

Do you want to work 10 times harder? Would you want to be held to a higher standard? Or do you think the road is challenging enough? Let me know: *@anthonycentore* or *@Thriveworks*. ❖

Anthony Centore is the founder of Thriveworks, a counseling company focused on premium clinical care and customer service with locations in eight states. He serves as the private practice consultant for the American Counseling Association and is the author of the book *How to Thrive in Counseling Private Practice*. He is a licensed counselor in Massachusetts and Virginia. Find him on Twitter: *@anthonycentore* or *@Thriveworks*.

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Risk Management for Counselors — By Anne Marie "Nancy" Wheeler

Do proposed regulations properly protect client privacy?

Question: I work for an agency as a substance abuse counselor. We were recently told in a staff meeting that the federal regulations governing privacy of substance abuse treatment information are changing. Are you aware of how that might impact my work?

Answer: To borrow a phrase from Bob Dylan, "The times they are a-changin'." Not only are the times changing, but so are the regulations on the confidentiality of alcohol and drug abuse patient records, found at 42 CFR Part 2. Originally promulgated in 1975, the regulations were designed to allay concerns that use of substance abuse treatment information in criminal prosecutions might deter substance users from seeking counseling and other needed treatment.

The proposed regulations, published Feb. 9, will be open for comment through April 11 at 5 p.m. Go to *federalregister.gov* and search "confidentiality of substance use disorder patient records." A full explanation of the many proposed changes are set forth in the proposed regulations.

The impetus for change was the development of new models of integrated care following the enactment of the Affordable Care Act, as well as the creation of an electronic infrastructure for exchanging patient information and an emphasis on performance standards and cost containment within the health care industry. The Substance Abuse and Mental Health Services Administration, which oversees these regulations, has a laudable goal of ensuring that patients with substance use disorders can participate in new integrated treatment programs without fear of adverse consequences, such as loss of employment, incarceration, discrimination and loss of child custody. However, some questions are being raised regarding whether the exact language of the proposed regulations might fall short in the area of patient protection.

For example, one of the many proposed changes calls for a relaxation of the current requirement, for most disclosures, that patient consent must specify the name or title of each person or the name of the entity to whom or which disclosure will be made. According to the proposed rule, the consent form could designate the recipients of information in a broad form, such as a health information exchange, or the form could designate "my treating providers" in lieu of specifically naming physicians, counselors and other providers. Unless a patient/client truly understands who will be receiving this information, the concern remains that it may not be truly "informed" consent to release information.

There are many other proposed changes in the 144-page document, including updated definitions, new requirements for security of electronic records and the "sanitizing" of electronic media after discontinuation of a program. I would strongly encourage you and your colleagues to read the regulations and offer your comments on specific proposed requirements that you support, as well as those requirements you believe may harm your clients or impose undue burdens on providers.

The question addressed in this column was developed from a de-identified composite of calls made to the Risk Management Helpline sponsored by the American Counseling Association. This information is presented solely for educational purposes. For specific legal advice, please consult your own local attorney. ❖

Anne Marie "Nancy" Wheeler, an attorney licensed in Maryland and Washington, D.C., is the risk management consultant for the ACA Ethics Department.

Letters to the editor: *ct@counseling.org*

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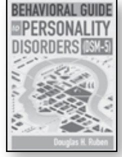

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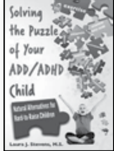

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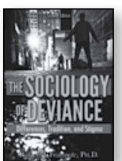

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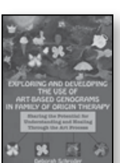

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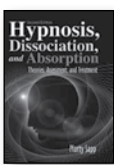

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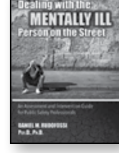

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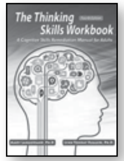

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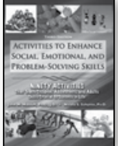

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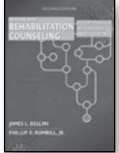

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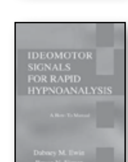

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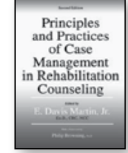

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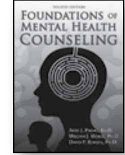

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Sex-related variations in neuroscience and endocrinology and their effects on mental health

Should you be taking into account the sex of your client when considering diagnoses, interventions or treatment plans? If so, how would you go about doing this, and what factors should you consider?

In counselor training programs, we are often taught that differences exist in prevalence rates among males and females for certain disorders. We are at times encouraged to consider sex when deciding criteria for membership in group counseling, particularly when running offender or survivor groups, for safety purposes or when it might simply feel more comfortable for participants. This article takes the question of sex differences one step further by exploring various explanations for potential sex differences and asking whether sex-related variations in brain structure and function, autonomic arousal and endocrinology (primarily levels of sex hormones) should factor into client care.

It is important to note that in this article, I am speaking to biological sex, which is influenced by chromosomal variations and levels of sex hormones. In doing so, I am not suggesting that a binary, sexually dimorphic categorization should be the basis for differentiation, but rather that sex-related variations in brain and physiological functioning may play an important role in mental health and efficacious counseling interventions.

Sex bias in research

Sex bias is a long-standing issue within a multitude of fields related to mental health. Bias is often present in the selection of research design, assessment measures and practices, diagnostic criteria, the sex of participants and in the analysis and interpretation of data. In 1992, Linda Gannon at Southern Illinois University at Carbondale suggested that as early as the 1970s, supporters of the feminist movement stressed the importance of developing inclusive models of human, not simply male, behavior. However, it was not until 1993 that the National Institutes of Health (NIH) Revitalization Act mandated the inclusion of females in human clinical trials. However, this mandate did not cover the use of females in nonhuman research (e.g., rodents).

Given notable fluctuations in female endocrinology over the estrous or menstrual cycles (depending on species), females were often deemed too problematic to include in highly controlled scientific research. In 2011, Annaliese Beery and Irving Zucker at the University of California–Berkeley contested this notion, reporting that eight of 10 biological fields still contained male sex bias in nonhuman biomedical research. This difference was most notable in neuroscience, with males outnumbering females by a 5-to-1 ratio and nearly 40 percent of studies not reporting sex. Pharmacology (a 5-to-1 ratio) and endocrinology (greater than a 3-to-1 ratio) also contained notable bias. Similarly, Kelimer Lebron-Milad and Mohammed R. Milad reported that although a significant amount of literature detailed learning, memory and fear extinction relevant to anxiety and posttraumatic stress disorders (PTSD), less than 2 percent of research included females.

By using only male mammals and relying solely on male brain structure, physiology and endocrinology, we build misleading models of addiction, stress and other issues that can distort behavioral and pharmacological interventions. Exclusively using male animals can also hinder researchers in identifying possible variations in responding that may be revealed only in the presence of both sexes. As the field of mental health moves forward, it will be important to consider sex-related neurophysiological variables in the etiology and symptom presentation of disorders and the best practice care of clients.

Sex differences in mental health

Debates surrounding sex and gender differences are notable in mental health. Women have historically been considered more emotional and emotionally labile, while men were thought to be more mentally tough, rational and physically oriented. Today, we still see these antiquated gender role distinctions perpetuating the stigma around males, in particular, seeking counseling. Notwithstanding (and at times owing to) such historical portrayals of males and females, sex differences in the prevalence of certain mental health disorders remain. Autism spectrum disorders (ASDs), conduct disorder, attention-deficit/hyperactivity disorder (ADHD) and schizophrenia tend to be higher in males, whereas females experience higher rates of mood disorders, PTSD and anorexia nervosa. Even within certain disorders such as substance abuse and PTSD, we see variations among males and females.

With addiction, general differences exist in the reasons that males and females start using. Males tend to initiate use in an effort to engage in more risky behavior and derive positive reinforcement, whereas females tend to initiate use to alleviate (largely psychosocial) stress. Similarly, childhood maltreatment may be a stronger predictor of adolescent substance use in females. Females also tend to transition into addiction more rapidly. The effects of stimulants can also be different for females and males, with a female's response varying over the

menstrual cycle. The menstrual cycle can also influence attempts at quitting and relapse, with stronger cravings taking place during the luteal phase when estrogen and progesterone decline.

Marked differences also exist with PTSD. Females are twice as likely as males to develop PTSD, with symptoms lasting four times longer, even though males on average experience more traumatic, and often more violent, events throughout life. Furthermore, female survivors of interpersonal violence develop PTSD six times as often. Examination of PTSD symptoms indicates that males tend to experience more anger and reexperiencing symptoms, whereas females likely experience more emotional numbing, restricted affect, avoidance responses and somatization. Females also experience greater psychological reactivity to traumatic stimuli and report feeling more shame and diminished belongingness.

However, researchers often muddle the concepts of sex and gender. This mislabeling can incite confusion and lead to difficulty in teasing apart the various sex-related contributing factors to mental health. Thus, in the examination of *sex* differences in mental health, it has been challenging to parse out nature from nurture, or ingrained, culturally defined gender stereotypes from physiological variations.

The interchangeable use of the terms *gender* and *sex* in literature underscores such difficulties and has created a heated debate around this topic. One side insists that attempting to delineate differences between males and females only perpetuates enthnocentric gender biases, whereas the other side emphasizes the importance of considering differences to improve mental and physical health interventions. Given advances in technology, there has been a recent reinvigoration of research investigating how differences in gene expression, patterns of development and connection between brain structures, and endocrine variations in and across males and females influence emotion, behavior, cognition and the prevalence and expression of mental health disorders. What follows is an overview of some of the recent findings and how they may apply to your work as counselors, counselor educators or clinical supervisors.

Sex differences in neurophysiology

Differences between male and female brains related to structural development and patterns of connection become conspicuous during adolescence with the influx of sex steroids such as androgens (e.g., testosterone) and estrogens. Other differences are present in genetic expressions that occur even before birth. Research led by Yale University's Nenad Sestan found that nearly 80 percent of the genes that are differentially expressed between sexes during the prenatal period are in males and have been linked to disorders such as schizophrenia and autism.

In a recent meta-analysis of sex differences in brain structure, Amber Ruigrok and her team from the University of Cambridge noted that males on average have a larger overall brain volume (taking into account body size) and a greater volume of white matter (the myelinated axons connecting neuronal cell bodies). Differences were also present in the regional volume of specific areas. In more than 2,000 brains, males (ages 7 to 80) on average had a larger gray matter volume in the right and left amygdala, putamen

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(involved in limb movement, some forms of learning, dopamine regulation and addiction) and posterior cingulate gyrus (which may play a role in the default mode network, or resting state activity in the brain, and has been implicated in ASD, ADHD and schizophrenia). Females often have a larger insula (involved in empathy, socioemotional processing, somatosensation, interoception and pain perception), thalamus and anterior cingulate cortex (active in emotion regulation, socially driven interactions, empathy-related responses and decision-making).

Variations have also been noted in the patterns of connectivity between brain regions. Earlier this year, researchers from the University of Pennsylvania School of Medicine detailed the use of diffusion tensor imaging to examine patterns of connection between brain areas in more than 900 males and females ages 8 to 22. Led by Ragini Verma, the team found that the connectome (the pattern and strength of connection between various subnetworks of brain regions) differed between males and females, with differences increasing through late adolescence. These differences help explain some of the cognitive and behavioral strengths in males and females. For example, males' enhanced motor and spatial skills reflected stronger structural connectivity in motor, sensory and executive functions. Females showed enhanced memory and social cognitive skills associated with stronger brain connectivity between areas related to social motivation, attention and memory.

Sex differences are also present in cerebral blood flow (CBF), functional anatomy and neurotransmitter levels. Females have increased CBF compared with males, with CBF shifting in response to circulating hormones. A higher CBF suggests that females may be better equipped to effectively and efficiently circulate psychotropic medications throughout their brains. CBF abnormalities have also been linked to depression, addiction and schizophrenia.

Males and females also show differential activation of the hypothalamic-pituitary-adrenal (HPA) axis — part of our stress response mechanisms that help to activate the fight-or-flight systems — and secrete different levels of stress hormones following the same stimulus. Females have a more responsive HPA axis and higher cortisol secretion after stress. This level of reactivity can also vary with the menstrual cycle. The HPA axis plays a role in anxiety, PTSD, depression, immune functioning and so on. These differences can also affect the functioning of the paraventricular nucleus, which has a role in reward conditioning and drug-seeking behavior in addictions. Furthermore, females have higher serotonin levels, but males synthesize serotonin faster. Again, these variations can influence differential rates of depression between sexes. The functioning of dopamine and oxytocin are also heightened in females. Dopamine plays an integral role in the brain's reward centers, reinforces the effects of many drugs and is implicated in schizophrenia.

> Microbiome transplants may prove beneficial in alleviating mental health symptoms that arise more frequently in one sex over the other.

Sex differences in the microbiota-gut-brain axis

Given the burgeoning research detailing the impact of gut microbiome on brain and mental health functioning, examining sex differences in the microbiota-gut-brain axis also proves quite interesting. The microbiome experiences developmental stages similar to that of the brain, with sex differences emerging during puberty and continuing into adulthood.

Males experience relatively stable microbial communities, while the female microbiome varies with cycling hormone levels. With decreasing levels of ovarian hormones, as the microbial community shifts, females are at an increased risk for mood disorders, sensitivity to pain and gastrointestinal difficulties. Not only do hormones influence the bacteria in the gut, but the bacteria directly impact levels of hormones and neurotransmitters such as serotonin, dopamine and norepinephrine.

Eldin Jasarevic, Kathleen Morrison and Tracy Bale reported that the transfer of the contents of an adult male mouse's caecal (beginning of the large intestine) into a pubertal female mouse masculinized the composition of the microbiota and elevated testosterone levels. These changes persisted into adulthood. Similar caecal transplant studies demonstrate how the introduction of new microbial communities can alter behavior, with the recipient's behavior taking on more of the behavior of the donor. Jasarevic and his colleagues suggest that microbiome transplants between males and females may prove beneficial in alleviating mental health symptoms that arise more frequently in one sex over the other.

Role of sex hormones

Interestingly, levels of circulating sex hormones influence nearly every single one of these variations between males and females. Blood flow, HPA axis functioning and levels of neurotransmitters are all regulated by gonadal steroid levels. Sex hormones are also thought to influence plasticity by way of myelination, the branching of dendrites and the formation of new synapses. Estrogen increases CBF as well as levels of 5-HT (serotonin receptors), dopamine and oxytocin. Given that estrogen enhances 5-HT neurotransmission, it also may accelerate the response to selective serotonin reuptake inhibitor treatment. Increased levels of estrogen and testosterone both enhance the functioning of the HPA axis and related corticosterone release and negative feedback loops.

Several studies have shown the protective benefits of testosterone in stress responses and a range of mood disorders. Similarly, estrogen serves as a protective factor against developing PTSD and anxiety disorders, and it also enhances fear regulation. So, in essence, where a female falls in her menstrual cycle at the time of a trauma may in part influence how likely she is to develop PTSD. In other words, a woman who experiences a trauma just prior to ovulation, when estrogen levels peak, may be more psychologically resilient to the trauma

than if that trauma occurred when her estrogen levels were lower.

In a provocative 2012 article, researchers Nikole Kirin Ferree, Malinda Wheeler and Larry Cahill reported that the use of emergency contraception, namely Ogestrel (a combination of exogenous estradiol and progestin), following sexual assault was associated with decreased posttraumatic stress symptoms. In addition, a team of researchers led by Enrique Baca-Garcia found that female suicide attempts increased when levels of estrogen and progesterone were low (early follicular phase) and that these attempts were more severe.

This is just a selection of the extensive research in this area. Although quite complex and at times contradictory, research detailing the effects of sex hormones on symptoms of mental health disorders is a quickly expanding area of study. It may very well lead to novel counseling interventions and supplements to talk therapy for a range of disorders.

Sex-specific psychotherapy?

In 2015, the federal budget dedicated $215 million to the growing field of precision or personalized medicine. This represents a move away from the one-size-fits-all model of care and embraces the discovery of new therapies from which to select when determining the best intervention for a particular client. This followed on the heels of the NIH's 2013 BRAIN (Brain Research through Advancing Innovative Neurotechnologies) Initiative, which is helping to revolutionize how we understand the human brain and thus prevent and treat a range of mental health disorders.

Glenda Gillies and Simon McArthur from Imperial College London have argued the need to better understand the role of estrogen and sex-related differences in mental health functioning and called for the use of this information in designing hormone-based therapeutic agents for both males and females. This is just one of the many potential implications that can be derived from the study of sex differences in the brain and related physiology.

However, Daphna Joel at Tel-Aviv University and her colleagues caution readers not to think of sex differences as a dichotomy, but rather as a complex and unique "mosaic" of differences related to sex, with more features common to males or females.

Implications for counselors

As research advances, we as counselors can benefit from understanding the implications of this knowledge base on how we assess, conceptualize, diagnose and develop treatment plans for clients. For example, if we know that aberrant levels of estrogen may be influencing the presentation of a symptom, we may find it beneficial to work with that client in a different manner rather than responding to long-standing gender stereotypes without such aberrations in hormone levels.

At this point, this approach is speculative, but it will be interesting to see how research progresses in terms of related clinical implications and how, perhaps, the therapeutic relationship and associated clinical interventions may play a role in this neurophysiological dynamic. Based on the currently available findings, what may be beneficial is to provide psychoeducation around the effects of sex steroids on mental health functioning. By doing so, we can empower clients to recognize that the functioning of their entire physical body has an impact on their mental health.

It may also be beneficial to work with allopathic, osteopathic and functional medicine practitioners to provide the best care for your clients. For example, if you are working with a male client with notable symptoms of depression, it may be beneficial to have him see a physician to assess testosterone levels as an adjunct to your ongoing counseling work.

Whether you believe that highlighting sex differences only perpetuates the problem of sex discrimination or you are eagerly exploring such variations, it is my hope that this article will help you stay informed about developments in this line of research and trends in the broader mental health world. Such knowledge allows counselors the opportunity to stay at the forefront of emergent mental health interventions and remain leaders among practitioners in mental health fields. ❖

Laura K. Jones, a national certified counselor, is a lecturer in the Health and Wellness Department at the University of North Carolina at Asheville. She serves as the co-editor, with Lori Russell-Chapin, of the Neurocounseling: Bridging Brain and Behavior column. Contact her at *ljones3@unca.edu*.

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Making diversity (and diverse experiences) work

Latinia Shell has more than 15 years of professional experience as a counselor and has worked in a variety of settings, including college counseling, school counseling, college teaching and outpatient mental health. A licensed professional counselor, Shell is the owner of Diversity Works-Counseling, Supervision, Consultation, Training (CSCT) and has two office locations in Lancaster, Pennsylvania.

Danielle Irving: Did you always know that you wanted to be a part of the counseling profession?

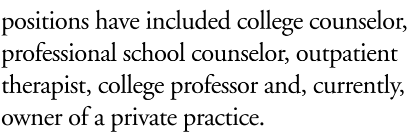
Latinia Shell: Ever since I was a high school student working in my school counselor's office to assist him with establishing a scholarship bank for seniors and seeing how he helped me and other students prepare for academics, personal/social concerns, college and the world of work, I knew that I wanted to be a part of the helping profession. In fact, I told my school counselor that I was going to return as a school counselor at the high school I attended.

Six years later, I became a school counselor in a neighboring school district. When a position opened in the district that I attended [as a student], I took a middle school counselor position at my alma mater, Edward Hand Junior High, and worked in the middle schools for six years. Finally, when a high school position opened at my alma mater, J.P. McCaskey High School, I took a position there, where I worked for three years. I resigned from my position to take a full-time faculty position once I obtained my doctorate degree.

My high school counselor has since retired. However, our paths have crossed often at the community college where he now works as a counselor part time and where I taught as an adjunct faculty member. I am proud to say that my former high school counselor, Allen Hopkins, was truly an instrumental part in planting the seed for my birth and journey as a professional counselor.

DI: Your story is amazing and very inspirational. What steps did you take to achieve this goal?

LS: Educational steps that I took to become a part of the helping profession included getting both a B.A. in psychology and an M.Ed. in counselor education from Millersville University and a doctorate degree in Counseling Psychology from Argosy University-Sarasota (Florida) Campus. Licensure and certifications include Pennsylvania licensed professional counselor, Pennsylvania secondary school counselor certification, national certified counselor, certified clinical mental health counselor and approved certified supervisor. Professional counselor positions have included college counselor, professional school counselor, outpatient therapist, college professor and, currently, owner of a private practice.



Latinia Shell

DI: What advice would you offer to a new professional who is struggling to identify a specialty or niche within the counseling profession?

LS: My advice would be to get as much diversified experience as possible. In doing such, you will be able to determine what your strengths, weaknesses, likes and dislikes are. You will get a feel for settings, clients and research interests that you have.

In all of the positions that I have had, the trend that I noticed is that I have enjoyed working both in education and the private sector, working with adolescents and young adults, having a diverse clientele, and programming and research initiatives dealing with diversity, multiculturalism, mental health and wellness. Through my vast experiences in the counseling profession, I was able to discover what my specialty/niche areas are, which include my passion for working with clients dealing with issues of race, identity, anxiety, depression, stress, life transitions and inclusion/diversity issues in school and work settings.

DI: That is wonderful advice. Would you mind speaking about your private practice and what the name Diversity Works-CSCT means to you?

LS: I am proud to announce that I am celebrating the three-year anniversary of my private practice. The name of my practice is symbolic of my passion and zeal for diversity and my commitment and dedication to making it work. My vision and mission is to have a practice that is committed to being inclusive in accepting all clientele, especially clients who are disenfranchised, as well as rendering excellent multicultural competent counseling services.

DI: What type of services do you provide?

LS: The CSCT acronym stands for the services that I provide: counseling for individuals, couples, families and groups; supervision for master's-/doctoral-level counselors interested in certification and licensure; and consultation and training for both diversity and mental health/wellness initiatives in education and private sectors.

DI: What can your clients expect to receive from a counseling session with you?

LS: My clients can expect to receive excellent quality services by being provided with a warm and inviting atmosphere [from] an empathetic relational counselor who makes clients feel comfortable [and] who is genuine, down to earth, competent and ethical. Clients can expect not to be judged but to be heard, understood and respected. Clients can expect to be challenged and to work on issues not only during the counseling session but also outside of the counseling session, by being given tasks to work on in between sessions.

DI: What advice would you offer to someone who is interested in building his or her own private practice?

LS: The advice I would offer is to seek business/entrepreneurial training as well as to get a mentor or business consultant in the foundational stages of building the practice. Years before I opened the doors to my private practice, I was laying the foundation by taking business classes that SCORE (formerly the Service Corps of Retired Executives) offered for a nominal fee, as well as free business mentoring services that SCORE offers to entrepreneurs in the United States. In addition, I sought and paid for several sessions with an entrepreneur in private practice who provided business consultation/coaching.

Another great way to receive information about owning a private practice is to obtain memberships with local, state and national counseling organizations, where benefits will include discounts for attending conferences, webinars, resources, as well as numerous opportunities for networking and meeting entrepreneurs in private practice.

DI: You have had several experiences in a variety of settings. In which setting have you gained the most knowledge?

LS: I have had experience working in settings such as public education, academia and the private sector. The settings where I gained the most knowledge include all of them. Each setting has taught me critical information in my professional journey as a counselor [and helped me] understand and learn more about myself as an individual. I would not trade anything for my journey. I encourage beginning counselors to do the same in gaining as much knowledge and experience from a variety of settings. Doing so will not only provide enriching experiences but will also allow for challenges and growth to occur.

DI: How different is online teaching versus traditional face-to-face teaching?

LS: It is very different in that online teaching requires a lot of work to be done on the front end in making sure that the course shell is detailed, accurate and up to date for students to see. Online teaching also requires daily participation in forums and in monitoring forum discussions. Face-to-face teaching is different in that rapport is easier to establish in person, as well as lecturing/classroom interaction being different in the delivery, with students being able to work in small groups and participate without technology difficulties as a barrier.

I have had experience with online teaching and traditional face-to-face teaching as both a student and a professor. Neither is better than the other; they are just different. In a perfect world, the blending of online and traditional face-to-face teaching would be ideal for both students and professors. We are living in the 21st century, where technology is a necessary skill and is here to stay. Many students rely on online classes, and many institutions, including Harvard, are offering online programs. I recommend that prospective college professors receive experience with both, not only to have the knowledge and skills but also to be more marketable. It is now not only desired, but many colleges are making it a requirement.

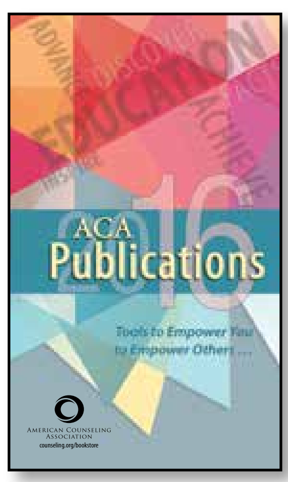
DI: The American Counseling Association has close to 56,000 members. Have I left anything out that you want our readers to know about you or your work?

LS: I think you have done a great job capturing the highlights of my professional journey as a counselor. If there is one lasting impression that I can leave about myself and my work as a counselor, it is that I know that I was born and put on planet Earth to be a counselor. It is my purpose, life's work and divine calling to be able to be present for people during their greatest times of need and assist with putting the pieces of their lives back together. There is no greater joy than knowing that a life was saved, a marriage was resurrected or a family was reunified because of my passion and commitment to helping people.

In closing, I'd like to say that the world is a better place because of the work that we do as counselors, and while we can't save the world, we all need to remember to "Each one, reach one, teach one." ❖

Danielle Irving is the senior coordinator for ACA's professional projects and career services department. Contact her at *dirving@counseling.org*.

Letters to the editor: *ct@counseling.org*



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This year, we're focusing on the fundamental human exchange that is unique and essential to counseling—the ability of counselors to connect with people, not just their problems or disorders. Let's spotlight the many ways in which all types of counselors empower others to live more fulfilling lives.

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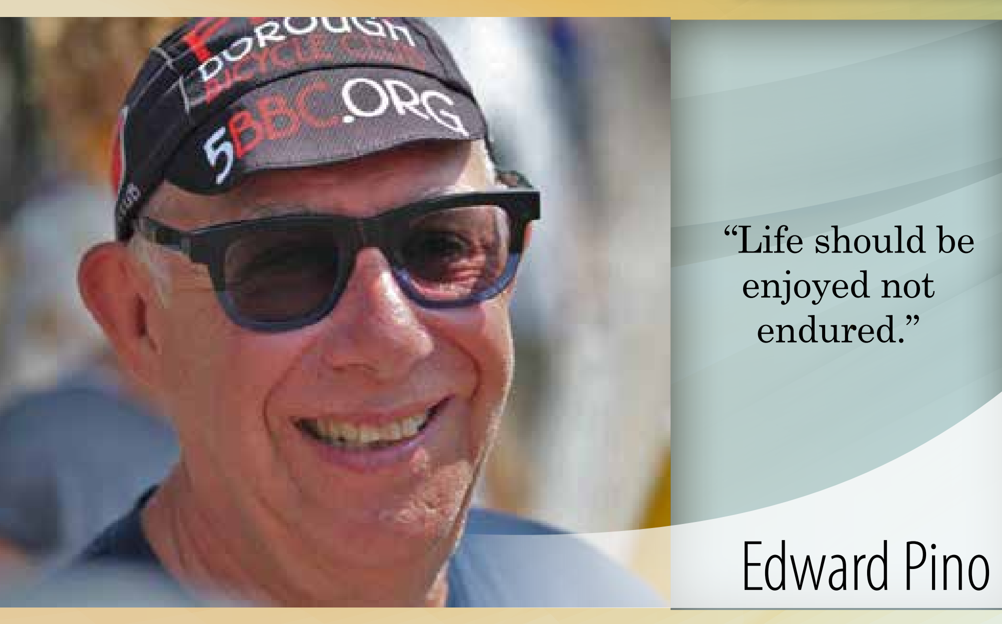
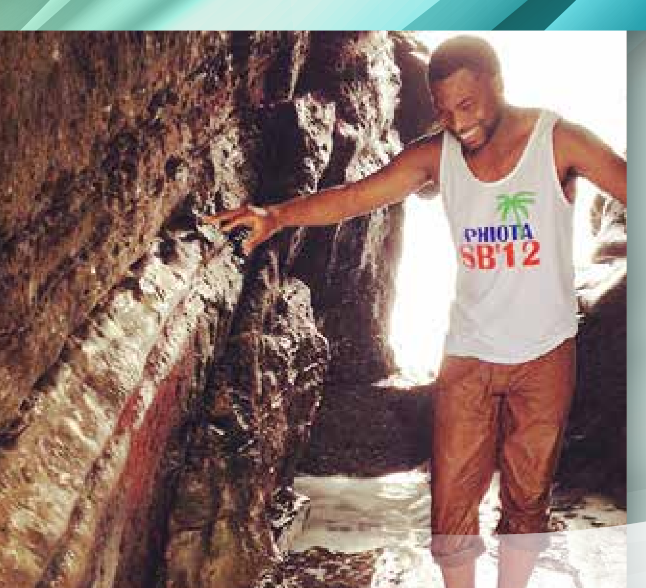


"Life should be enjoyed not endured."

Edward Pino

“I encourage my clients to step out of their comfort zone and try new, fulfilling experiences.”

Shannon Stonebrook

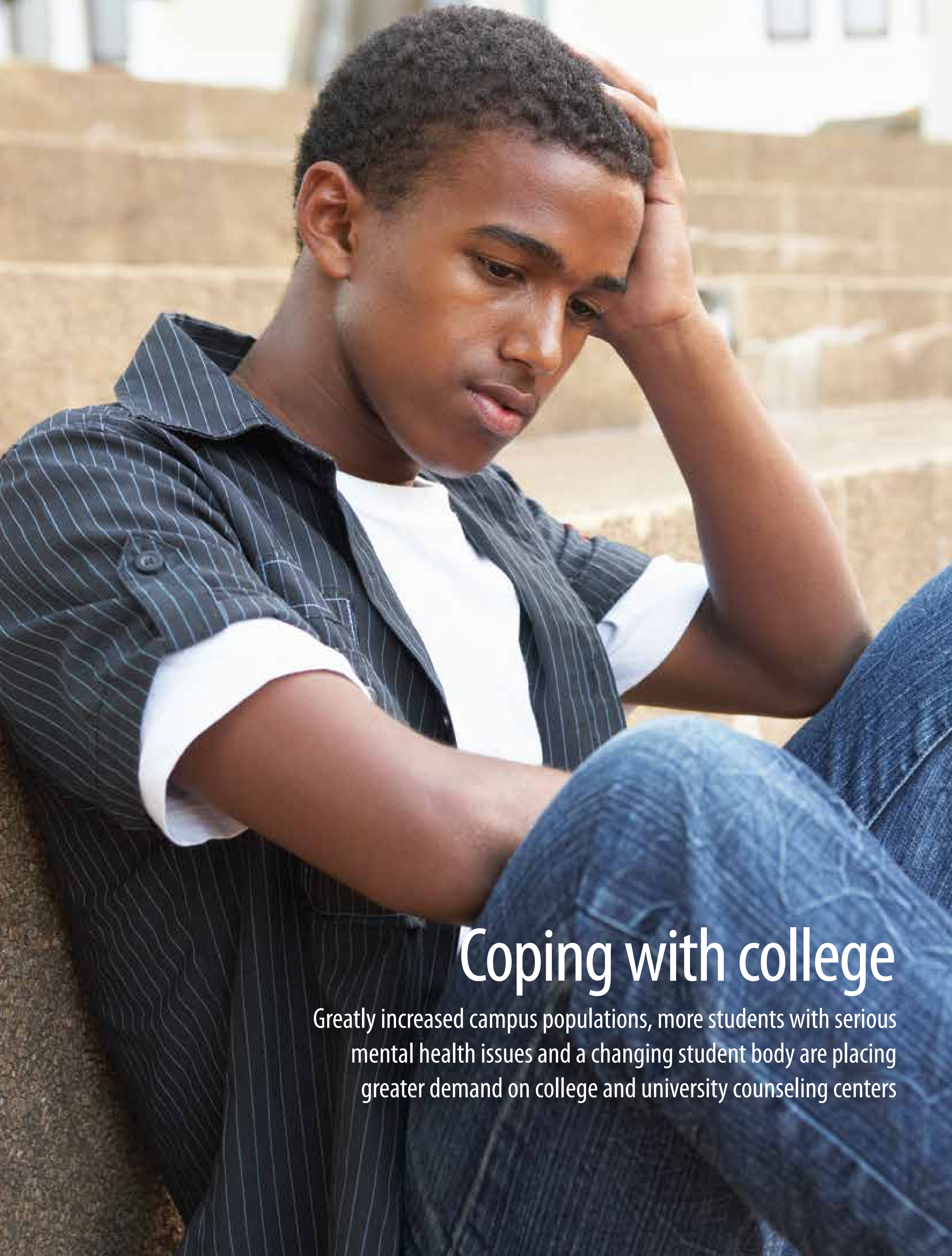


“Let me help you move through this journey called life and embrace your truth, your essence, and your authenticity. Learn to just be!”

Marlon Boutin

“I work with my clients to embrace the concept that only when we nurture ourselves, can we truly nurture others.”

Katrina Seigerman



Coping with college

Greatly increased campus populations, more students with serious mental health issues and a changing student body are placing greater demand on college and university counseling centers

By Laurie Meyers

Often parentally micromanaged, pressured by high expectations, grappling with depression and anxiety, a bit socially awkward or just a little bit lost in a strange new world, today's college students are seeking counseling in greater numbers than did previous generations, according to college counselors and other experts.

Those who counsel students point to various factors for this surge in clients, including greater overall awareness of mental health issues, higher rates of depression and stress, and a huge increase in the overall student population at colleges and universities. According to the Institute of Education Sciences, the research and statistical arm of the U.S. Department of Education, between 1992 and 2012 (the latest year for which statistics are available), the number of students enrolled in degree-granting institutions has grown by 39 percent.

National surveys conducted by the American College Counseling Association (ACCA), a division of the American Counseling Association, indicate that the percentage of students struggling with serious mental health issues has also increased. In addition, 42.4 percent of the almost 75,000 undergraduate students who completed the 2015 annual American College Health Association National College Health Assessment reported experiencing greater than average stress within the past 12 months, and 10.3 percent reported feeling tremendous stress. When asked about depression and anxiety during the previous 12 months, 35.3 percent of survey respondents reported feeling so depressed that it was difficult for them to function; 57.7 percent indicated feeling overwhelming anxiety.

At the same time, staff growth at college and university counseling centers has typically failed to keep pace with this increased burden. As a result, these counseling centers are often scrambling to stay on top of their caseloads, and college counselors are using a variety of campus resources and outreach methods to meet the needs of today's students.

Welcome to the new world

One of the defining features of the traditional college experience is leaving the nest. But many students in the current generation are having trouble finding their wings, according to college counselors. That's in part because, generally, today's young adults are used to their parents managing many aspects of their lives, says Suzanne Degges-White, who supervises student counselors as part of her role as a professor and chair of the Department of Counseling, Adult and Higher Education at Northern Illinois University.

"We're dealing with helicopter parents," she says. "They've done so much [for their children]. And then when you get to college, your teachers don't care if you do your homework, and your parents aren't there to remind you."

"There's this idea that kids need protecting, so when they get to college, suddenly if they don't like a class or their roommate, this may bring them in to the counseling center," adds Degges-White, the ACA Governing Council representative for the Association for Adult Development and Aging.

ACCA President Amy Lenhart agrees, saying that the students she sees often seem ill equipped to handle many of the demands they face, such as managing

their academic workloads, interacting with instructors and other students, and even getting to class on time. Both Lenhart and Degges-White say they regularly encounter students who have trouble making any kind of significant decision on their own. In some cases, parents are still trying to make all the decisions for their college-age children, says Lenhart, who works with students on general counseling issues and career concerns at the counseling center at the Preston Ridge Campus of Collin College in Frisco, Texas.

"I can tell you that even in counseling, parents want to make appointments [for their son or daughter]," she says. She has also encountered parents who want to sit in on their son's or daughter's career counseling sessions. In such cases, it is important for counselors to set boundaries and let parents and students know that it is time for these young adults to make certain decisions on their own, Lenhart says.

The consequences for students who struggle to make decisions and manage their lives can be severe, Degges-White says. Not studying, skipping classes and failing tests can quickly lead to academic probation, she points out. Although it is easy to dismiss such behavior as laziness or a lack of interest, Degges-White contends that would be a mistake. Instead, counselors need to ask students about their classes, including why they're not going or why they think they're failing a particular subject, she says. The answer may be related to poor time management, and many colleges have workshops to which counselors can refer students.

Of course, there may be other underlying reasons. "Sometimes students don't go to classes because they are not interested in them," Degges-White says. "Maybe they aren't suited to the subject or even need a different major."

However, if the behavior is due to a lack of accountability, counselors should work with students on making decisions and then accepting the consequences, Degges-White says. She likes to use choice theory to help students explore the options available to them. "How are the choices you are making now going to get you to your goals?" she asks. "If they're not, what other choices can you make?"

ACA member Nick Patras, a licensed professional counselor and assistant director of the counseling center at Texas A&M University-Commerce, dissects the time management process with his clients. Sometimes students come to the counseling center after their first semester having failed several classes and hoping for an easy and instant answer, he says.

Instead, Patras delivers a dose of reality, but he also tries to provide helpful strategies to get the students back on track. "Do you have goals? Do you have projects? Do you have them broken down into stages, or do you wait until the last minute?" he asks these students. "I educate them on how to plan and manage projects by breaking them down into little bites."

Knowing your students

Josh Gunn, the director of counseling and psychological services at Kennesaw State University in Georgia, urges college counselors to be aware of their campus culture and who their students are. For

instance, Kennesaw State's student body features a significant percentage of first-generation college students, he notes.

Parents who have been to college generally impart at least a minimal amount of knowledge to their children about how college works, but first-generation students don't have that advantage, says Gunn, a member of ACCA. Not knowing anything about college life can pile on an additional layer of uncertainty and stress, he points out.

First-generation students are also more likely to be putting themselves through school, which may mean working a job in addition to attending classes, Gunn says. For these students, academic struggles may be at least partially tied to general financial stress or simply not having as much time to focus on their studies, he explains. Counselors should consider how putting students in touch with other resources such as the financial aid office or an academic adviser might relieve certain stressors for students, he says.

It's also important for counselors to keep in mind that not all college students are young adults fresh out of high school. Some students, especially on today's campuses, are individuals who are beginning or returning to college later in life, Degges-White points out. These students are confronting many of the same stressors as their younger peers, but they will be juggling those stressors with work and family concerns, she says.

Lenhart's institution is a community college, which means that its students don't have to meet the enrollment requirements that applicants at four-year colleges and universities do. Because of this, she explains, some of those who enroll — for example, a 50-year-old student who hasn't taken classes since high school — might not be ready for the courses he or she is taking. It's important for counselors to consider factors such as these when students come in with academic problems, Lenhart says. What seems like (or may in part be) a time management problem could actually involve a skills deficit for which counselors should refer students to the tutoring center and their academic advisers, she says.

When academic performance is a predominant concern for students, it affects every area of their lives, including their mental health, Gunn says. Therefore, when students come to the counseling center and present with depression, anxiety or stress, it is important for counselors to ask how their courses are going, because academic concerns may be exacerbating whatever other issues they are concerned about, he says.

Counselors should also keep in mind that if a student is struggling with academics, that issue doesn't necessarily go away just because the mental health problem has been addressed. "If you've cured someone's depression but they flunk out, you've failed," Gunn says.

Making new connections

Joel Lane, who studies the theory of emerging adulthood and is the coordinator of the clinical mental health counseling program at Portland State University in Oregon, says that, traditionally, a person's late teens and early 20s were when attachment relationships shifted from one's parents to peers and romantic partners. Possessing the ability to form and maintain these healthy attachments is especially important in

- Year-round admission
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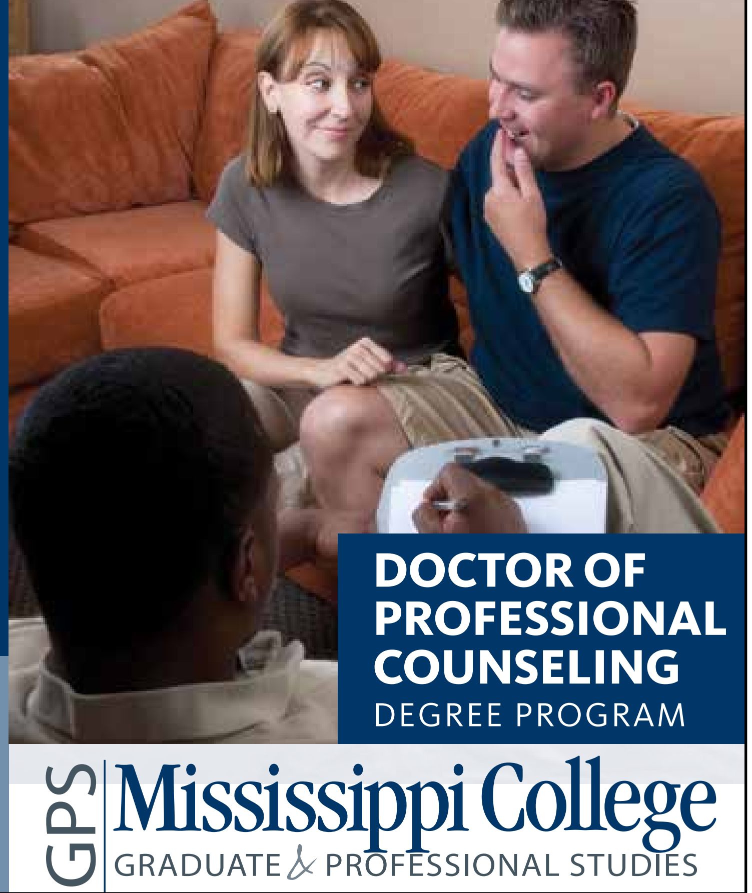
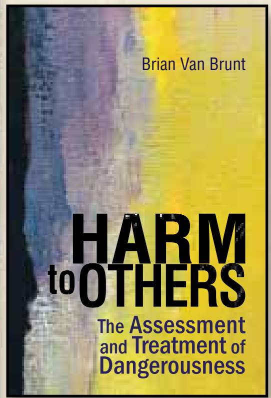


New!

Harm to Others: The Assessment and Treatment of Dangerousness

Brian Van Brunt



"This wonderful book is a much-needed guide for all of us working in the field of risk assessment for violence. I have worked in this field for many years and have amassed a lot of experience, and I will have this book on my desk so I can refer to it every time I get that gut-wrenching call that begins, 'I am worried that this person could act out violently. What should I do?'" (This opinion is not the opinion of the FBI. It is solely the opinion of Dr. Mary Ellen O'Toole.)

—**Mary Ellen O'Toole, PhD**
Author, Speaker, Senior FBI Profiler (ret.), Forensic Behavior Consultant

Harm to Others offers students and clinicians an effective way to increase their knowledge of and training in violence risk and threat assessment, and it also provides a comprehensive examination of current treatment approaches. Although the text includes many examples from K–12 and college/university settings, which are particularly relevant for mental health professionals in school settings, the underlying concepts and suggestions are useful for counselors, psychologists, and social workers who face these issues in their daily practice.

In an easy-to-understand, jargon-free manner, Dr. Van Brunt shares his observations, extensive clinical expertise, and the latest research on what clinicians should be aware of when performing risk and threat assessments. In addition, he offers numerous examples from recent mass shootings and rampage violence to help explain the motivations and risk factors of those who make threats. Two detailed case examples are presented to illustrate key concepts related to assessing dangerousness. Treatment options are then described, using a variety of diverse case studies to demonstrate concrete approaches for clients who have been identified as at risk for violence following a threat assessment.

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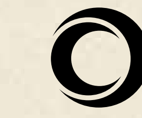

American Counseling Association

times of transition and can affect not just an individual's personal life but his or her professional life as well, he says.

However, for members of the millennial generation, that process has become more complex for several reasons, according to Lane. One is that young adults (ages 18-25) are "younger" psychosocially than previous generations have been. Millennials' identity exploration is taking place at a later age when they are no longer adolescents but when they do not consider themselves adults yet either, he says. Also, because their parents often continue to manage their lives, these young adults may be less likely to seek other sources of emotional support, at least in the "real" world, Lane continues. Where today's young adults tend to turn to seek support and interact with others is social media, he explains. And although social media may be good for those purposes, it does not generally prepare young adults for making connections and conversing in their classes, in social situations or on the job, Lane contends.

Unfortunately, many college counselors report that social anxiety — which negatively influences a person's ability to form new attachments — appears to be much more prevalent among today's students than in prior generations and is a factor in a significant number of their clients' cases. Patras says that about half of his cases involve social anxiety as either the presenting concern or an aggravating factor. Often, he says, the students he sees simply do not understand how to interact with others.

"They don't know how to talk to people, how to carry on a conversation or how to ask someone out," Patras says. "It's partly socioeconomic" — the university where Patras works is located in a rural, impoverished area — "but [it's] mostly because they are interacting on social media and not in real life."

Lenhart and Degges-White have observed this as well. Although none of the three counselors believes that social media is inherently bad, they do think it has caused a significant shift in how young adults interact with one another. "They say they are 'dating,' but they might just be interacting on Facebook or through texting," Patras notes.

Although it's true that adolescents and young adults are establishing social

networks online, they typically do this in solitude at their computers or on tablets instead of learning face-to-face communication and interaction skills, Degges-White says. She adds that many of today's college students spend their social time video chatting with friends from home rather than going out and making new friends.

Technology does provide its own kind of connection and access to a wide array of helpful resources, Lenhart acknowledges, but it is also easy to hide behind, particularly for those with social anxiety. "We want them to actually be out in the world," she emphasizes.

Which is why some college counselors are gently but firmly pushing students out of their comfort zones.

For instance, Patras holds workshops on social skills. He teaches students how to integrate into an unfamiliar group by first finding one person within the group to talk to. When participants ask how to start a conversation with someone they don't know, he tells them to ask the other person about himself or herself. "Everyone likes to talk about themselves," he says. In the workshops and in individual counseling, Patras also teaches students relaxation and emotional regulation skills such as mindfulness meditation and deep breathing to help ease their anxiety.

Lenhart asks students to try attending social events such as campus group meetings or parties. "Just challenge yourself," she urges students. "Make sure you have a way you can leave if you get uncomfortable, and just stay, even if it's only for 10 minutes."

Degges-White believes a combination of cognitive behavior therapy and a bit of desensitization therapy is effective in helping students overcome social anxiety. Her counseling center also refers students to small group sessions in which students can practice talking to one another. Degges-White has also found that giving "homework" assignments to students, such as having them talk to at least one person in one of their classes each week, encourages greater social engagement. Because a lack of social skills is becoming more common in young people, even high schools are beginning to offer groups that focus on these skills, she says.

Managing mental health needs

College counseling centers don't just deal with students' issues related to time management, academic adjustment, social skills, being away from home for the first time, getting used to living with other people and, as time goes by, choosing a major and career path. The age range when most people go to college — late teens to early 20s — is also the age at which serious mental illnesses such as depression, bipolar disorder and schizophrenia often appear. College is also a time when many people choose to begin experimenting with drugs and alcohol, which can lead to substance abuse problems.

Unfortunately, the level and length of care that college counselors can provide to students experiencing serious mental health issues varies greatly. Patras says that his counseling center currently has the resources to work with students for as long as they need it and are willing to do the work. According to Patras, the small city of Commerce has only two mental health professionals, and many of the university's students don't have private insurance, so the school's counseling center is a particularly essential resource.

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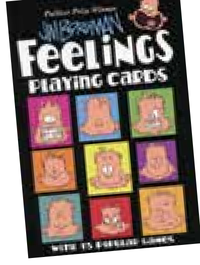

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Additional resources

For those who would like to learn more about the topics addressed in this article, the American Counseling Association offers the following resources.

Books (*counseling.org/bookstore*)

- *Group Work and Outreach Plans for College Counselors* edited by Trey Fitch and Jennifer L. Marshall
- *Harm to Others: The Assessment and Treatment of Dangerousness* by Brian Van Brunt
- *Eating Disorders and Obesity* by Laura H. Choate
- *A Contemporary Approach to Substance Use Disorders and Addiction Counseling*, second edition, by Ford Brooks and Bill McHenry
- *Treatment Strategies for Substance and Process Addictions* by Robert L. Smith

Webinars (*counseling.org/continuing-education/webinars*)

- "Counseling School and College Students" with Richard Joseph Behun, Julie A. Cerrito and Eric W. Owens (part of the ACA Trauma Webinar Series)

VISTAS Online articles (*counseling.org/knowledge-center/vistas*)

- "Counseling International Students" by Julia F. Kronholz
- "Distressed College Students Following Traumatic Events" by Simone F. Lambert, Joyce C. Lambert and Samuel J. Lambert III
- "Helping College Students Develop Mental Wellness Skills Through Journaling Techniques" by Julia Y. Porter
- "Needs Assessment for Counseling GLBT Clients" by Rebecca Gardner, Joshua Adkins, Whitney Gillespie and Cristen Wathen
- "Passport to Wholeness: The Effects of a Campus Mental Health Fair on Help-Seeking Attitudes" by Lucinda C. West and Anita Knight
- "Recovering College Students: Practical Considerations for College Counselors" by Mark S. Woodford
- "The Effects of a Brief Mindfulness Intervention on Self-Compassion Among Undergraduate College Students" by Danielle Richards and William E. Martin Jr.

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The American College Counseling Association, a division of ACA, focuses on fostering student development in colleges, universities and community colleges. Visit *collegecounseling.org* to learn more about the division and to access its array of resources.

Other institutions are forced to limit the number of sessions that each student is entitled to or else maintain long waiting lists because demand is so high, Lenhart says. Because of these limitations, many college counseling centers focus on triage. This involves getting the most severe cases in or, if necessary, referred out for hospitalization or psychiatric care immediately, and using brief interventions such as solution-focused therapy for less severe cases, she says.

Some colleges are relying more frequently on group therapy, which doesn't count against students' allotted center visits and has the added benefit of helping students interact with others, Lenhart says. This is especially important in cases in which students are dealing with depression or social anxiety, she adds. Groups can also be particularly beneficial for students dealing with grief, working through issues related to their sexual or gender identity and a wide range of other challenges.

Gunn says some of the counselors in his center are taking on the role of case managers in the more complex cases. These counselors get students who just got out of the hospital or have special needs set up with a psychiatrist or an on-campus counseling group.

College counselors are also reaching out to students to raise their awareness of the many services that counselors can provide; distributing psychoeducational materials and doing public screenings; and educating faculty and staff on spotting the signs of behavioral problems.

Gunn's counseling center gives regular workshops on everything from decision-making to general wellness to sexual assault awareness. He believes that college counseling needs to become more proactive; not just to let students know where the center is located and say, "Come see us when you're ready," but to actively look for potential problems in hopes of preventing bigger ones. His staff regularly provides information about identifying behavioral problems to the resident life program, department heads and other faculty and staff. In addition to encouraging prevention, he hopes that counselors can help create campus cultures in which the belief becomes that safety is everyone's responsibility.

Lenhart bemoans the lack of residence halls on the community college campus where she works because she believes that hall staff — due to their more frequent contact with students — serve as a sort of first line of defense for identifying students who may be struggling and in need of counseling. That doesn't mean the college's faculty and staff aren't vigilant. In fact, she says, faculty and staff often bring students to the counseling staff's attention and even walk those in need of help to the center if need be.

"We train them [faculty and staff] for what to look for," she says. "Dropping grades; changes in appearance, such as becoming disheveled, not bathing; maybe acting out in class; maybe being angry — any kind of change in behavior that is unusual for that student."

"We have to work harder at promoting counseling to students because of the come-and-go nature of our [community college] program," Lenhart says. "I think, sadly, the assumption is that counselors at community college campuses are like guidance counselors."

So, Lenhart and her counselor colleagues educate, educate, educate, conducting psychoeducational sessions and distributing informational fliers for national events such as Depression Awareness Day. Professors also have the

counseling center staff visit classes and give presentations on stress and anxiety, she adds. She believes that classroom sessions not only help demystify what college counselors do but also get students more comfortable with the idea of coming to the counseling center.

Many colleges now have a kind of "college 101" class for incoming freshmen. The counselors interviewed for this article said it is important for college counseling centers to be involved with these efforts, either by providing educational materials or giving presentations.

Patras' counseling center maintains liaisons within all of the university's major academic departments and also works closely with campus police, who refer students to counseling if they have had trouble related to alcohol or drug use. The counseling center also educates other faculty and staff about possible indicators that students may need help, such as unusual acting-out behaviors (for example, outbursts in class), slipping grades or a previously responsible student who is now missing classes or not completing assignments.

Behavioral intervention teams are also becoming common on college campuses. The problem-solving teams typically include counselors and representatives from campus departments such as student affairs, campus police or security, student conduct and resident life, explains Brian Van Brunt, a past president of ACCA and author of *Harm to Others: The Assessment and Treatment of Dangerousness*, published by ACA. These teams meet regularly — typically once a week — to exchange information. The goal is to identify incidents or patterns that might indicate a possible problem — such as increased substance abuse arrests or a rash of suicide attempts — and to formulate a course of action with the goal of preventing larger problems.

Events such as the 2007 mass shooting at Virginia Tech provided the impetus for the creation of behavioral intervention teams, Gunn says. Even so, he cautions college counselors not to focus exclusively on such large-scale events. "Don't waste all your time preparing for a mass shooting that may never happen," he says.

Events such as a student's suicide are more common, he explains, and likely to have a significant effect on campus mental health. To reach as many students as possible, counselors need to encourage an environment of multidepartmental sharing, he adds.

In many ways, counselors interviewed for this article say, college counseling has become a campuswide effort.

~

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Falling short of perfect

Significant societal barriers, unrealistic expectations and the unattainable quest to "have it all" leave many women with a damaged self-image and questioning their true value

By Laurie Meyers

This past December, a major pop culture event occurred for which millions of people had been waiting longer than three decades: *Star Wars: Episode VII* was released. Finally, the story from 1983's *Return of the Jedi* was continuing. Many fans reserved tickets two months in advance, while others camped out in line overnight to be part of the audience for the first of the film's showings. Individuals active on social media reasoned that it was essential to see this latest installment of the *Star Wars* series as soon as possible to avoid tripping over spoilers.

As with any work of art, people held widely divergent views of the film. In print and online — particularly on social media — passionate discussions were held on virtually every facet of the new movie, but one of the most frequently broached topics involved actress Carrie Fisher. People weren't usually talking about how Fisher's character, Princess Leia, was now a general or how great it was to see one of the original characters in the newest film or even the quality of Fisher's performance though. Instead, the comments most frequently referred to her graying hair and extra weight. The overall sentiment was that Fisher was not aging "well."

At the same time, no significant accompanying discussion took place about Harrison Ford's (Han Solo's) graying hair or Mark Hamill's (Luke Skywalker's) prodigiously grizzly beard. Instead, the refrain heard throughout social media was: What happened to the princess in the gold bikini?! (For those who have somehow managed to resist the force of the original *Star Wars* trilogy, Fisher — as Princess Leia — had two scenes in *Return of the Jedi* in which she was held prisoner while dressed in a gold-colored leather and metal bikini. The image of Fisher in the costume has become iconic.)

As Fisher herself said in a 2011 blog post discussing her decision to become a spokesperson for the weight loss company Jenny Craig: "You know, I swear when I was shooting those films, I never realized I was signing an invisible contract to stay looking the exact same way for the rest of my existence."

Fisher's "invisible contract" is representative of the expectations that women face in American society today: to remain young and beautiful forever, to work harder to be considered equal to men (and yet be paid less) and to be a perfect daughter, mother and wife or partner — all while doing the majority of the housework, child rearing and caregiving. Despite the significant strides women continue to make toward equality, societal expectations still lead many women to think that they can (and should) "have it all." But that picture is acutely unrealistic, say counselors.

"Having it all means being able to fulfill multiple expectations simultaneously — the perfect appearance, perfect relationships, perfect mother and perfect career," says Laura Hensley Choate, a licensed professional counselor (LPC) who has written extensively about women's and girls' issues. "It means being perfect according to societal standards for each of these roles, but even if this were possible, it also means achieving them all simultaneously."

The problem, counselors say, is that these standards are perniciously presented to women not just as goals that *can* be achieved but as expectations that *must* be met. And when women fall short of these standards, they often view their unsuccessful attempts as personal failures rather than as an understandable inability to meet unreasonable expectations. This perspective can cause feelings of frustration, inadequacy and shame and, in some cases, lead to more serious problems.

"These expectations are so unreasonable and unattainable, and much of it is out of an individual's control," comments Vanessa McLean, an LPC from Richmond, Virginia, whose specialties include women's issues. "It is easy to see how women become plagued with anxiety, self-doubt and negative cognitions that can easily spiral into anxiety disorders or depression."

By identifying and countering these harmful societal influences, counselors want to help women separate self-image from societal expectations — and perhaps even start changing and setting the expectations themselves.

Chasing eternal youth and beauty

Throughout much of history, women were valued only for their beauty and fertility, says Choate, a member of the American Counseling Association.

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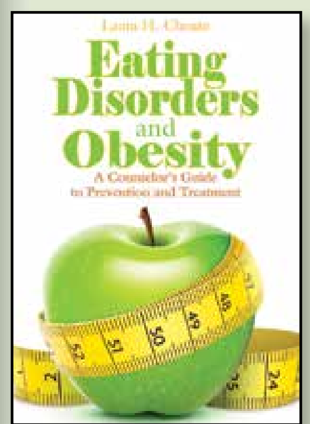

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Although these qualities are no longer the sole sources of a woman's worth, youth and beauty are still the most valued, she continues, and once a woman ages and those qualities are diminished, she loses value. In contrast, Choate says, research has shown that the characteristics most prized in men — wealth, power and status — increase with age, meaning that men generally gain value as they age. This disparity is evident in popular culture, particularly in films, which frequently pair young women with much older men, but not vice versa, she notes.

In society at large, this translates into an internalized mandate for women to fight against aging by any means necessary: products, diets, surgery and so on, says Choate, a professor of counseling education at Louisiana State University. Although we live in a youth-obsessed society, the pressure is mostly one-sided, she notes. "Men do not feel this same pressure. Certainly not to the same extent that women do," Choate says.

The youthful ideal that women are supposed to maintain is in itself unrealistic, McLean says. "It isn't just attractiveness that is the ideal but an obsession with physical perfection," she explains. "Perfect hair, perfect skin, perfect body, perfect teeth. … And the message is not only geared to young single women but to all women."

"Women now have equal rights and opportunities to pursue education and careers," McLean continues, "but if you consider the message that mainstream media send, both overtly and covertly, the message is still that women's primary value is sex, [which equals] physical attractiveness."

Working more for less

Women have largely seized the opportunity to pursue advanced education and careers, but on a societal level, their contributions in the workplace are not as highly valued as those of men — not just symbolically but also literally, experts contend.

According to a 2014 study by the U.S. Census Bureau, the median annual salary for women is 79 percent that of the median annual salary for men. That's 79 cents for every dollar a man makes. A 2015 comparison by the U.S. Department of Labor measuring weekly salaries found that women make 81 cents for every dollar that men make. "Women often feel more pressure in the workplace to perform,

simply to get equitable recognition and pay," McLean says.

Many women's wages are affected by factors such as maternity leave and child care, as are their career trajectories, which are often linked to making better wages, says Nadine Hartig, an associate professor and chair of the Department of Counselor Education at Radford University in Virginia. Beyond the physical demands of pregnancy, giving birth and raising children, women are often confronted with choices related to balancing their work and life roles. These are choices that men generally do not have to make, Hartig points out. Even if a woman's husband or partner assumes some of the child-rearing and household responsibilities, the bulk of those responsibilities will typically still fall on the woman, says Hartig, a member of ACA.

Hartig notes that she made a career choice herself because of the demands of motherhood. "I chose not to go into a tenure track right away mostly because I thought it would kill me to do that at the same time as raising children," she says.

Many women wrestle with the challenge of how or if to try balancing motherhood and work, knowing that the decisions they make could mean delaying or even derailing a career. Women are sometimes judged negatively for taking time away from work, even for maternity leave, but they are also susceptible to being judged for returning to work as quickly as possible and continuing to pursue their careers, note Hartig and Choate.

When a woman who is a mother seeks a promotion, her dedication to her children may be questioned, along with her ability to get the work done, says Hartig, an LPC who also maintains a small private practice. "This can be done in really insidious ways, with comments such as, 'I'm concerned you won't have enough time for your family [if given the promotion].' Generally, men do not face this same kind of judgment. No one questions a man's commitment as a father if he takes a promotion."

McLean says that when parenting and household duties are factored in, research has shown that women perform 50 percent more daily work than men.

"The reality is that working mothers still tend to serve as 'managers' of the home," agrees Choate. "They are the ones who keep up with the schedules, the tasks that keep the household running, the doctor's appointments, the school needs. And while research shows that fathers do help out, it is the mothers who tend to assign the tasks to keep everything on schedule."

"So, the mothers have to manage the home tasks — which of course take a great deal of mental energy for planning and can lead to worrying — while fathers tend not to carry this burden with them," Choate continues. "And the societal expectation is that a good mother will keep the family's schedule flowing seamlessly. If things don't run well in the home, the expectation is that the mother is not doing her part well. And for single mothers, this pressure is even greater because they are not only the managers of the home, but they also have to carry out all of the tasks with very little help or support."

Sadly, for many women, the harshest critics they face are themselves, Choate says. They try to have it all and then feel like failures when they can't achieve the impossible. In essence, she says, "having it all" boils down to "figuring out a way to look young, thin and beautiful, be home with the kids as much as possible, be a superstar at work, have lots of successful friendships, have a blissful romantic

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Breaking free of the mold

Choate says counselors can help their female clients uncover the unrealistic expectations they are operating under. "What are the actual standards they hold up for themselves in order to feel they are a success? Actually putting these expectations into words is the first step in helping to change them," she says. "Where did they learn these expectations? How did they come to internalize these expectations? Did they learn them from parents? Teachers? Coaches? Popular media? Whose approval are they seeking?"

Once a client realizes she is responding to outside forces rather than considering options that might be right for her, the counselor can help her identify ways of creating a healthy balance that fits her life, Choate says. The counselor should have the client ask herself what makes sense for her given her personal strengths and resources.

"This will look different for everyone," Choate says. "What are realistic and meaningful goals that respect self-care and balance versus living up to a never-ending treadmill of others' expectations? Helping our clients separate the difference between societal 'shoulds' versus what each client actually wants for herself will be very freeing for her."

In Choate's book *Girls' and Women's Wellness: Contemporary Counseling Issues and Interventions*, published by ACA, she talks about strategies couples can use to strike a balance in household duties. Rather than trying to decide how to divide tasks exactly 50-50, she suggests that couples talk about particular duties that each partner prefers. For instance, one might prefer folding laundry to vacuuming, or washing dishes rather than taking the trash out. Couples should also talk about who will keep track of items such as bill paying, appointments and other deadlines. The most important goal is for both partners to be satisfied with the division of labor, Choate says. It is also important for partners to be flexible enough to temporarily take on more or less responsibility when needed, she adds, such as one partner tackling extra household tasks when the other partner has a project that requires extra hours.

The messages that affect women's self-image often start in childhood. Go to CT Online (*ct.counseling.org*) to read an online exclusive about counselors helping girls to defy societal stereotypes.

Hartig also helps her clients re-examine the stereotypes they have been taught, particularly as they relate to body image. "I believe the first step is assessing where clients' narratives about their bodies began," she explains. "For example, was the client told she was fat by a parent, or did the client gain a significant amount of weight and feel differently about his or her body? Identifying the struggles a client has about his or her body is important to begin working toward self-acceptance. Often, a negative body image is indicative of feelings of inadequacy and shame. Working on these feelings can lead clients to finding peace with their bodies."

"Some of the ways that we work with clients on self-acceptance is to explore the negative self-talk they experience and where this self-talk originated," Hartig continues.

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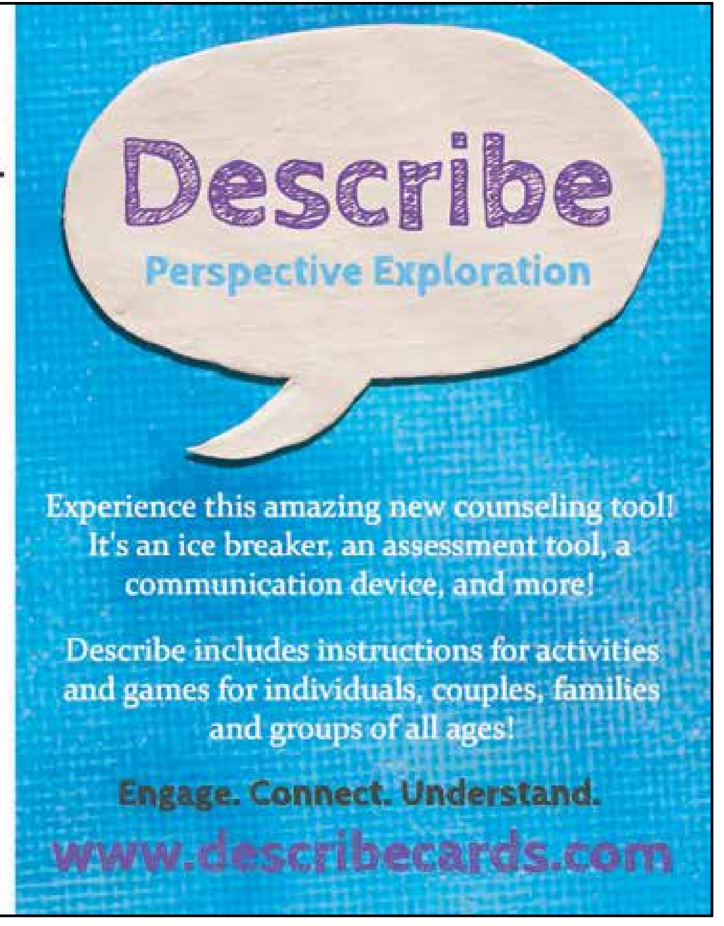

"Coaches, parents, teachers and friends all can have an immense impact on self-talk. Counteracting this self-talk with CBT [cognitive behavior therapy] can be very helpful. Creating a new narrative about the client's self and body is also helpful. For example, a client who can say 'My body is strong and my body helped me escape some pretty hard situations' is on the road to appreciating her body."

Hartig also notes the importance of counselors being aware that negative societal messages about appearance and body image are even greater for women who are not white or heterosexual. "Women of color face even greater assaults on a positive body image [because] our culture has an ideal that is rarely inclusive of all women — or people," she says. "Women who identify as lesbian or bisexual are also often marginalized and misunderstood with regard to body image."

"Internalized self-loathing is a natural consequence of media and other outlets that do not embrace the beauty of diversity and realness of people," Hartig says. "Understanding these issues specific to different cultural groups is key to helping clients with body image issues."

McLean uses brain-based psychoeducation to help women understand why they feel they need to meet society's unrealistic expectations. For instance, she explains that humans are hard-wired to seek social approval, so it is normal for people to want to conform. McLean then helps clients to understand their own expectations and fears and to recognize and reframe cognitive distortion. She encourages women to explore how to balance their lives around their personal values rather than around social expectations.

Hartig likes to use narrative therapy to examine her clients' struggles with the expectations they feel they need to meet. As she listens to clients' stories, she finds it particularly important to note losses — for example, dreams or plans a woman may have had to let go of in one part of her life, such as her career, to attend to an aspect in another domain, such as family.

For instance, Hartig had a client who had decided not to have a second baby because she wanted to pursue tenure. However, after achieving tenure, she didn't find it particularly satisfying and felt that she had given up the chance to have another child for nothing. It was important for the woman to grieve this loss, Hartig says.

Hartig encourages clients to grieve such losses by helping them develop rituals for letting go. This might involve a client writing a letter to herself and then burning or shredding it, releasing balloons, journaling or even holding a "funeral" for what was lost. The funeral ritual might include gathering pictures or symbols of what the woman lost, putting them in a box and burying them.

Once the client is ready, Hartig helps her to "reimagine and recreate," building a narrative around what she wants her life to be going forward and how she can make that happen.

"For some, writing this plan down makes sense and is helpful," Hartig says. "This can take the form of a 'letter from your future self' or free writing/journaling about hopes for the future. This process can also be done in the therapy session, as some clients do not respond well to written homework. I think the crucial element is to gently invite the client to envision a life that looks different than what ... she originally planned, once the grief has dissipated."

Until society rejects the picture of perfection that is "having it all," counselors can play an important role in helping women strike a balance that allows them to have what they need.

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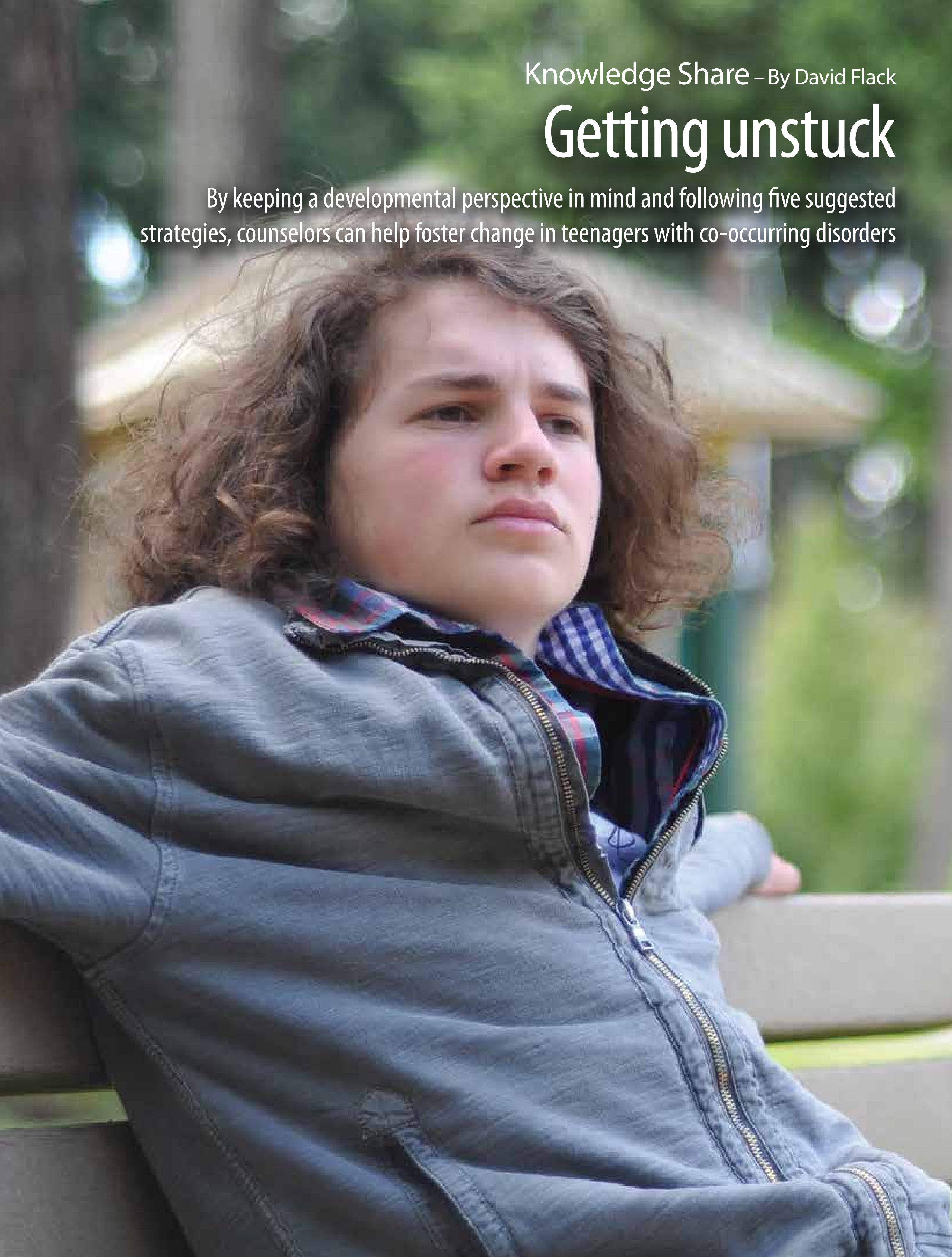

Knowledge Share – By David Flack

Getting unstuck

By keeping a developmental perspective in mind and following five suggested strategies, counselors can help foster change in teenagers with co-occurring disorders

Andrew never knew his father. At age 4, he witnessed the death of his mother from an overdose. She was heroin dependent, and they were living in a car at the time. After her death, Andrew entered the foster care system. Between the ages of 4 and 15, he experienced more than a dozen different placements. Not surprisingly, with each move, his behavior became increasingly problematic.

At age 9, Andrew started drinking alcohol. By age 11, he was using alcohol and marijuana regularly. He discovered meth as a 13-year-old and went to inpatient care for the first time. He ran away after four days. When he was 15, he ran from the group home where he was living.

When Andrew entered treatment at age 16, he was on probation and had just moved into a transitional living program after several months on the streets. When he started treatment, he met the criteria for multiple substance use disorders. He also had pre-existing mental health diagnoses that included posttraumatic stress disorder (PTSD), attention-deficit/hyperactivity disorder, conduct disorder and major depressive disorder. At that time, Andrew said he had no interest in stopping his substance use because "that's not a problem for me."

In his treatment journal, Andrew wrote, "Lots of times I feel like I'm living in some kind of black hole. I'm alone, but not really, because everything's there, because I just can't escape it no matter what I try. It's black there, because that's what black holes are, right? But black is really all the colors at once, every single one of them. And that's too many damned colors if you ask me."

Understanding the stuckness

Very few teenagers enter substance abuse treatment by choice. They show up due to legal mandates, school requirements, family pressure or other external reasons. Often they see treatment as the least bad choice — only slightly better than detention, suspension or homelessness. Like Andrew, these teens often appear unwilling or unable to do things differently, even though their current behaviors are clearly causing problems. In other words, they're stuck.

I propose that our primary task as counselors is to help these teens get unstuck — not behave better, fulfill mandates or even stop using substances. We can hope those other things happen. I certainly do. However, it seems to me that those changes can occur only when an individual gets unstuck.

When helping teens get unstuck, we need to maintain a developmental perspective as counselors. Various developmental models exist, with most including a progression of stages that individuals move through, and each stage featuring specific tasks to be accomplished. The primary stage-specific tasks for adolescence are generally considered to be developing identity and establishing autonomy. As part of establishing autonomy, it is normal for adolescents to question, rebel against and ultimately reject the plans of authority figures, including the most well-intended plans of professional helpers.

Sometimes, those well-intended plans lead to reactance, which is a tendency to resist influences perceived as a threat to one's autonomy. Many adolescent treatment programs are designed in ways likely to exacerbate reactance. We tell adolescents what, when, why and how. In residential programs, we restrict personal items. In wilderness programs, we often take away everything. Then we wonder why participants are unsuccessful. Worse, we blame them — declaring them in denial, resistant to treatment, unwilling to engage or simply noncompliant. Instead of helping, we've increased their stuckness.

Reactance can be exacerbated by what I think of as *developmental debt*. Most developmental theories state that if a person doesn't successfully complete the tasks for a specific stage, then he or she remains in that stage. It seems to me that this might not be accurate. Instead, sociocultural and biological factors keep pushing individuals forward, even when tasks at another stage are unresolved or only partially completed.

With every push forward, an individual becomes less likely to complete the next stage. This leads to an ever-growing developmental debt. Much like with a

credit card that's never fully paid off, the person not only will always have a balance due, but he or she will get further behind each month.

With this developmental perspective in mind, I propose five strategies for fostering change with teenagers who have co-occurring disorders. Inspired by motivational interviewing, stages of change, narrative approaches and existential psychotherapy, I have found these strategies useful for helping this population to overcome rigid thinking, get unstuck and start moving forward.

Slow down

Traditionally, drug treatment programs have assumed that anyone entering services is ready to get and stay clean. This simply isn't true. Change is a process, not an event. When we slow down, we're able to help participants move through that process. Developed by James Prochaska, John Norcross and Carlo DiClemente, the stages of change is an evidence-based transtheoretical model that identifies five steps in the process of change:

- **Precontemplation:** The person doesn't believe he or she has any problems related to the target behavior, so the person sees no reason to make changes. To help participants in this stage, we can focus on building a therapeutic alliance, validate the participant's lack of desire to change and provide objective information.
- **Contemplation:** The person is considering the possibility that a problem might exist but hasn't yet decided if change is necessary. To help participants in this stage, we can explore the pros and cons of continuing to use substances, gently identify contradictions, help make links between substance use and mental health challenges, and provide opportunities to imagine or experience alternatives.
- **Preparation:** The person has identified a problem related to the target behavior and is deciding what to do next. To help participants in this stage, we can encourage small initial steps or experiments, continue to explore and solidify motivation for change, and help eliminate obstacles to change.
- **Action:** The person has decided to change the target behavior, has developed a plan and is now putting that plan into action. To help participants in this stage, we can explore ways to implement change, provide support, build self-efficacy and remain solution focused.
- **Maintenance:** When the new behavior has become habit, the person has entered this stage. I propose that six months of sobriety is a good milestone for this. To help participants in this stage, we can provide ongoing support, continue to explore real or perceived obstacles and foster resiliency.

In addition to these five stages, there's *Recycle*, which occurs when a participant reverts to behaviors from an earlier stage. When a participant recycles, many helpers blame the person's lack of skills, situational factors or unwillingness to change. Extenuating circumstances may certainly be present, but it seems to me that recycles occur because we push participants into the action stage too quickly. As such, recycles are potent reminders that we should slow down and revisit earlier stages, looking for unfinished or overlooked business.

Identify their motivators

Teens often enter services believing that they're free of problems or that their only problem is something external. It may not seem like success to some, but the change process has begun when teens

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report treatment as the least bad option, state that their only problem is that others think there's a problem or make similar comments. These may not be the motivators we desire for participants, but change requires meeting them where they are at, not where we want them to be.

We can help clients discover and deepen their motivators by using the "Five R's" from William Miller and Stephen Rollnick's motivational interviewing:

- **Relevance:** Why is change important?
- **Risks:** What are the risks of changing? What are the risks of not changing?
- **Rewards:** What will you gain from change?
- **Roadblocks:** What are the obstacles to change?
- **Repetition:** Review these elements at each session.

Sometimes, to help participants solidify their motivators for change, we need to assist them in developing problem-recognition skills. We can do this by exploring what defines a problem; nurturing mindfulness; and creating an inclusive, nonjudgmental treatment environment.

Approaches from narrative therapy can also be helpful. Teens with co-occurring disorders typically enter treatment with problem-saturated stories. These tales of stuckness have become the defining stories for their lives. Help them discover new stories and further increase problem-recognition skills by:

❖ **Externalizing the problem:** Instead of "having" a problem or "being" a problem, assist participants to view problems as existing outside themselves. This helps remove pressures rooted in blame, shame and defensiveness. Take this even further by encouraging participants to think of problems as characters in their stories.

❖ **Seeking exceptions:** We build and sustain problem-saturated stories by ignoring times when the problem wasn't in control. Seeking exceptions involves assisting participants to discover those ignored times. These exceptions hold the keys to change, so explore them in great detail.

❖ **Reauthoring stories:** Once exceptions have been discovered, participants can start reauthoring their problem-saturated stories. Reauthoring gives them the opportunity to create new, more empowering stories with plots that focus on moving forward.

Some teenagers are so stuck that they're unable to identify any exceptions to their problem-saturated stories. In these cases, it can be useful for counselors to add a fourth approach to those cited previously: *creating exceptions*. One way for these teens to break the cycle of stuckness is to try something new. I've had participants explore belly dancing, glass blowing, rock climbing, rugby, hand drumming and much more.

Expect ambivalence

As I've noted, the change process has begun when a teen's thinking moves from "I don't have a problem" to "My only problem is that other people think there's a problem." When this occurs, the participant has moved into the contemplation stage of change. This stage is about ambivalence, which can be defined as simultaneously believing two seemingly contradictory ideas.

Ambivalence is common for all teenagers, who desire the privileges of adulthood while retaining the comforts of childhood. In the case of substance-using teens, there is often another, more complex layer — wanting to fix their problem while continuing to use. Andrew described this ambivalence well: "Using has really messed up my life, but I don't think I'll ever stop. When I'm high, the bad feelings go away. I don't think about the past, and I don't care about the future. For a little while, my brain shuts up and I can pretend everything's OK."

Some professional helpers focus solely on the reasons to stop using, perhaps believing that any discussion about the possible benefits of drug use will be seen as an endorsement. This simply isn't true. Helping youth such as Andrew get unstuck requires a sincere, nonjudgmental exploration of both the pros and the cons of substance use. Here are a few other ideas for resolving ambivalence:

❖ **Normalize the process.** Change is hard. It conflicts with deeply ingrained behavioral patterns and neural pathways. It requires us to ignore the stories we tell about who and what we are. It requires us to face the unknown. Because change is hard, we'd rather stick to the known, even when it is not effective or useful anymore. Helping participants realize that ambivalence is common can be essential to helping them get unstuck.

❖ **Explore the risks of changing.** High-risk behavior is common in the lives of many teens with co-occurring disorders. Paradoxically, these teens are often risk avoidant. As Prochaska, Norcross and DiClemente noted in 1994, change "threatens our very identity and asks us to relinquish our way of being." This is dangerous stuff for anyone, but for stuck teens, it can feel especially risky. Helping them make lasting change requires exploring the risks involved.

❖ **Foster self-efficacy.** Albert Bandura wrote that self-efficacy is "the belief in one's capabilities to organize and execute the courses of action required to manage prospective situations." In other words, it is a person's belief in his or her ability to succeed. Teens with low self-efficacy avoid challenging tasks, focus on negative outcomes and quickly lose confidence in their ability to be successful. They have very little interest in attempting to change.

❖ **Disrupt rigid thinking habits.** Teens with co-occurring disorders typically exhibit all-or-nothing thinking, catastrophize, deny having problems and blame others. These rigid thinking patterns reinforce their ambivalence. Resolving ambivalence requires them to think between the extremes. Traditional cognitive behavioral approaches identify these thinking patterns as irrational, erroneous and maladaptive. I prefer the term *thinking habits*, because habits can be changed.

❖ **Address existential concerns.** Irvin Yalom identified four "givens" that define an existential perspective to psychotherapy: death, meaninglessness, freedom and isolation. Professional helpers sometimes shy away from these existential concerns, especially when working with adolescents. However, these givens are very much present in the lives of teens and can contribute significantly to both stuckness and ambivalence. Acknowledge these givens and explore them with participants.

Become trauma-informed

The Substance Abuse and Mental Health Services Administration defines trauma-informed care as "an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives." Trauma-informed care includes the use of carefully developed approaches that reduce the likelihood of retraumatizing participants

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while integrating safety, trustworthiness, choice, collaboration and connection into all interactions.

Studies show that as many as 75 percent of teens in treatment for substance use disorders have experienced some form of traumatic stress. This occurs when an individual is exposed to a potentially traumatizing event or situation that overwhelms his or her ability to cope. Traumatic stress can be caused by a one-time experience or complex trauma, which can be defined as the experience of multiple traumatic events. Traumatic stress can lead to PTSD, a severe anxiety disorder that develops after exposure to traumatic stress. PTSD is a clinical diagnosis that requires the presence of specific symptoms, such as nightmares about the traumatic event, avoidance of stimuli associated with the event, increased arousal and hypervigilance. Regardless of whether they meet the diagnostic threshold for PTSD, teen trauma survivors often exhibit the following:

- **Hyperarousal:** Survivors can become extremely vigilant about their surroundings and often experience high levels of anxiety, which leads to sleep problems, trouble concentrating, feeling constantly on guard or being easily startled.
- **Intrusion:** Memories, flashbacks, and nightmares can continue long after the original traumatic exposure. Additionally, survivors sometimes unintentionally reenact aspects of the trauma. For example, teen survivors often engage in highly risky behaviors.
- **Constriction:** Attempts to avoid intrusion frequently result in survivors withdrawing from the world both physically and emotionally. Agoraphobia, substance use, limited social interactions and dissociation are a few examples of constriction.

When an individual has both a substance use disorder and traumatic stress, we usually assume that the trauma led to using the substance. However, substance use often leads to trauma exposure — or further exposure. In addition, pre-existing mental health challenges and a variety of other factors can increase the likelihood of trauma exposure. Whether trauma leads to drug use, drug use leads to trauma or a more complex scenario is present, substance-abusing survivors often find themselves perpetually stuck.

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Even though risky behavior is evident in the lives of most substance-abusing teens, and especially those with trauma histories, these youth are frequently risk adverse, with their risky behaviors serving as ineffective attempts to avoid risk or distractions from their past trauma. Some adolescent survivors are so obsessed with safety that they resort to substances and other maladaptive methods in an effort to find it. Still other teens lead lives so constricted that they barely participate in life. According to Judith Herman, in all these cases, trauma has "cast the victim into a state of existential crisis" in which all choices likely lead to even further stuckness.

Create connectedness

Edward Hallowell wrote that connectedness "is a sense of being a part of something larger than oneself. It is a sense of belonging, or a sense of accompaniment. It is that feeling in your bones that you are not alone. … Connectedness is my word for the force that urges us to ally, to affiliate, to enter into mutual relationships, to take strength and to grow through cooperative behavior."

For teens with co-occurring disorders, this sense of connectedness is typically missing. I believe that isolation exacerbates all life problems, so I strongly propose that the first step toward ensuring a valuable therapeutic experience is helping participants move toward increased connectedness. In clinical settings, we can focus on two types of connectedness: group cohesion and therapeutic alliance.

Group cohesion: It seems to me that groups should be part of the treatment plan for any teen with co-occurring disorders. That said, for change to happen in groups, a strong sense of cohesion is essential. We can help achieve group cohesion by remembering this simple formula: *Cohesion = Shared Fun + Safety.*

When working in groups, it is essential that we create safe spaces. This includes physical, emotional and social safety. We can create a sense of safety by modeling what we expect. That means being consistent and reliable, treating participants and co-facilitators in a welcoming manner and ensuring that groups are fully inclusive.

Some treatment approaches seem to assume that participants are fragile, hopelessly damaged or completely dysregulated. Fun activities and laughter have no place is such approaches. That's a shame. Shared fun activities build connectedness between group members and provide valuable opportunities to practice interpersonal skills. In addition, the use of fun and games helps alter negative preconceived notions of treatment, provides entry points for less verbal participants and helps teens reauthor their stories to include a world where laughter is the norm.

Therapeutic alliance: Numerous studies show that a strong therapeutic alliance is the most important indicator of positive outcomes when working with teens. When we take time to foster a strong alliance by genuinely embracing our participants' real motivators, we stop being an adversary and become an ally. This allows us to gently challenge the ambivalence, thinking habits and other roadblocks that keep participants stuck.

Edward Bordin wrote that a strong therapeutic alliance is composed of three elements: a positive bond between the therapist and participant, agreement regarding the tasks of treatment and agreement about the goals of treatment. In other words, there is congruence between the participant and the therapist. It seems to me that there also exists a need for transparency. Here are a few ideas for this:

❖ **Explain what you're doing as a counselor.** Take time to explain the theory behind your therapeutic approaches. In addition, explain to the teen what you hope to achieve by asking a particular question or assigning a specific homework task. This not only increases transparency but also improves buy-in.

❖ **Remember that relationships are reciprocal.** We expect participants to be honest. They should get the same from us. Don't disclose excessive amounts of personal information, but do answer questions that have been sincerely asked. Be genuine and model openness.

❖ **Use concurrent documentation.** Before ending individual sessions, write your progress note. Then have the participant read the progress note and write his or her own summary of the session. This may seem a bit clumsy at first, but in my experience, most participants quickly embrace the process.

Addiction as an attachment disorder

Substance abuse specialists familiar with attachment theory invariably report an inverse relationship between substance use disorders and healthy interpersonal attachments. In traditional treatment, unhealthy interpersonal attachments are generally considered the result of addiction. There is no doubt that heavy substance abuse is likely to exert a negative influence on relationships. However, there is mounting evidence that insecure attachment styles are risk factors for problematic substance use.

There are two basic concepts that are important for us to consider. First, if we don't have opportunities to observe caregivers engaging in effective emotional regulation, we may resort to substances in an effort to manage uncomfortable feelings. Second, if we don't connect to other people in meaningful, emotionally satisfying ways, we will find something else to fill that void.

Andrew referred to this void as a black hole made of all colors and tried to fill it with alcohol, drugs and significant acting-out behaviors. Other teens try to fill their voids with gangs, gambling, food, sex or video games. When we slow down and meet participants where they are at, we are able to help them get unstuck and start the change process so that they can see all the colors, not just black. ❖

Knowledge Share articles are developed from sessions presented at American Counseling Association conferences.

David Flack is a licensed mental health counselor, chemical dependency professional and child mental health specialist. He lives in the Seattle area and has worked for the past dozen years exclusively with teenagers who have co-occurring disorders. He has special interests in the comorbidity of substance use and trauma in adolescents, the use of experiential learning in clinical settings and the unique challenges faced by LGBTQ teens. Contact him at *david@davidflack.com*.

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JCD Article: ACA306, Choosing Assessment Instruments for PTSD Screening and Outcome Research

Learning Objectives: Reading this article will help you:
1) Examine the utility of six PTSD assessment instruments.
2) Understand how these assessment tools can be used for PTSD screening and outcome research.

Continuing Education Examination

1) Prevalence rates of posttraumatic stress disorder (PTSD) are anticipated to increase in the next decade because of recent:
   a) Epidemiological findings
   b) Prolonged military engagements
   c) Acts of mass violence
   d) Changes in diagnostic thresholds for PTSD

2) Some estimates indicate that individuals diagnosed with PTSD are ____ more likely to meet diagnostic criteria for another disorder.
   a) 90 percent
   b) 80 percent
   c) 60 percent
   d) 50 percent

3) Which of the following is considered the "gold standard" for PTSD assessment?
   a) Self-report screening instruments
   b) Clinician-rated screening instruments
   c) Self-report checklists
   d) Structured clinical interviews

4) Out of the six assessment instruments evaluated, which yielded significantly more conservative (i.e., lower) effect size comparisons?
   a) Mississippi PTSD scale (M-PTSD)
   b) Clinician Administered PTSD Scale (CAPS)
   c) Impact of Event Scale (IES)
   d) Posttraumatic Stress Diagnostic Scale (PDS)

5) Effect size comparisons indicated equivalent overall effect sizes for five out of six instruments evaluated.
   ____ True ____ False

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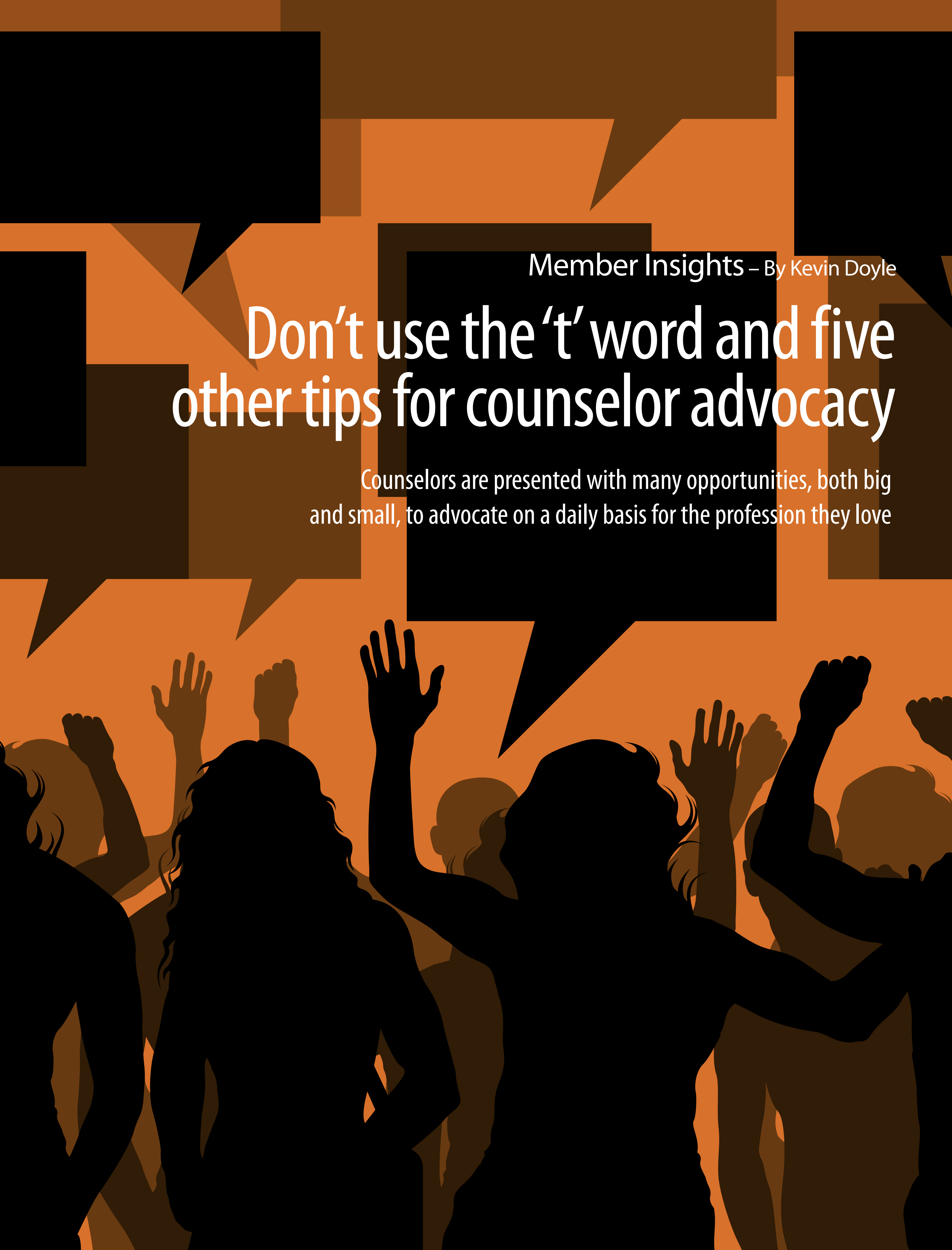

Member Insights – By Kevin Doyle

Don’t use the ‘t’ word and five other tips for counselor advocacy

Counselors are presented with many opportunities, both big and small, to advocate on a daily basis for the profession they love

After 30 years in the counseling profession, I have arrived at the conclusion that we counselors are sometimes our own worst enemies. When a unified voice could be the key to advancing our profession — such as with current efforts to expand reimbursement for counselors' services under Medicare, initiatives to standardize our licensing standards and outreach to get more counselors hired to positions within the Department of Veterans Affairs — we at times seem to be fighting our own internal battles instead.

How, then, can the individual counselor do his or her part to advance the profession that we all love? In the spirit of helping the counseling profession achieve the status that 40 years of licensure would indicate, I'd like to offer six concrete, yet relatively simple, suggestions.

First, as my students would corroborate, I have a visceral resistance to using what I call the "t" word: *therapist*. Although probably well-meaning in most instances, when counselors use this word, they miss opportunities to use an even better one: *counselor*. The same principle exists for use of the word *therapy* when *counseling* could be used.

In our culture, most people do not know the differences between counselors, social workers, psychologists and even psychiatrists. Each time that we call ourselves by the correct name (*counselor*), we are taking advantage of an opportunity to educate the public about our profession — to help with our own branding, if you will. Similarly, each time that we use *therapist* or *therapy*, we are missing out on that same opportunity and in a small way contributing to the ongoing diminution of our professional identity. When referring to a multidisciplinary group of helping professionals, using *therapy* or *therapists* is, of course, appropriate.

A second concrete action that each of us can take is to refer to other counselors. Obviously, our primary obligation is to our clients, and if the appropriate and best referral is to a helping professional in one of our sister professions, then so be it. But in making referrals, we are afforded another opportunity to help our profession advance, so we should include professional counselors as often as possible when we refer.

In my hometown of Charlottesville, Virginia, several licensed professional counselors got together a few years ago and formed a loosely organized group. We meet monthly for informal support and discussion and engage in quarterly trainings together for required continuing education. But in addition, we have also established an active professional network that has allowed us to learn more about the expertise of local counselors, which has greatly enhanced our ability to make appropriate referrals. Rarely does a week go by without a member of our group posting a message to our distribution list asking for help in identifying a fellow counselor to work with a particular type of client. Referring to other counselors, when appropriate, is one of the best ways that each of us can support our profession.

My third suggestion relates to the electronic age in which we currently operate. We must not underestimate the power of the Internet. Unfortunately, many counselors in our community do not have websites, so the referral process I outlined above is often complicated by the fact that most clients want to read about the person they were referred to before pursuing services with that professional. Because of that, we may be forced to refer to a professional from another discipline who does maintain a website. Lest counselors be discouraged by expense, several low-cost or even free web-design templates are available (for example, see *weebly.com*, *wix.com* and *web.com*). Using these or other templates, the main cost involves purchasing the domain name and hosting the site, which is typically quite affordable (often less than $100 per year). In addition to generating referrals for your practice, having a website helps to solidify the presence of counselors on the Internet

and further legitimizes our profession in the eyes of the public.

A fourth step in advocating for our profession induces fear in some counselors and may not be for everyone: talking to the media. Local newspapers, radio stations and television outlets are on a continuous quest for fresh content related to issues of the day. Some counselors routinely turn these requests down (I know, because they refer the media to me), missing another chance to educate the public about themselves and the profession.

Dealing with the media can be tricky, of course, but simply discussing what our profession does can be a valuable public service and an opportunity to teach about what counselors do. Commenting on particular cases or specific clients would be problematic and even potentially unethical, but participating in an interview on a particular issue, such as a counseling approach, what counselors do or a topic of interest to the local community, could be entirely appropriate and valuable. American Counseling Association staff members are available for consultation on talking to the media as well.

Getting to know your state and local legislators is a fifth way for counselors to engage in advocacy for the profession. State legislatures vary greatly, but most are composed of part-time legislators who spend much of their time in their local communities. These legislators are almost always extremely open to meeting with constituents (another word for *voters*!). Waiting until an issue is in front of the legislature to visit with your elected representative is often too late. By that time, whatever opposition exists may have already made its position known, meaning you may be up against a formidable adversary in a politically charged environment. A better approach is to proactively establish a relationship with local legislators. This can be done by inviting them to visit the program where you work, introducing them to other counselors, considering honoring them for work they may have done that is helpful to your clients or considering making a campaign contribution. Any or all of these steps can make a real difference when counselors in your state legitimately need the help of the legislator on a particular issue.

It seems that we earn the right to express our displeasure only when we actively engage in advocacy.

If you are uncomfortable or overwhelmed with the idea of visiting your local legislator, think about going as a group. Several counselors, perhaps with different specialties, can attend a meeting together, allowing the elected official to learn from multiple perspectives on a single visit and maximizing the effectiveness of your time. Remember, legislators are people just like us.

Finally, a sixth suggestion relates to the all-important governing bodies that oversee the practices of many of us: state licensure boards. Early in my career, my role in state professional associations led me to attend numerous meetings of our state board of counseling. Not only was this necessary and valuable as it related to the issues under consideration, but it also contributed to my interest in serving on the board and eventually resulted in my appointment to this position in my home state of Virginia. Before my appointment, while attending the meetings and advocating for things that weren't necessarily in line with the board's thinking at the time, I received a wonderful compliment when one of the board members said to me, "We don't always agree with what you have to say, but we appreciate the way you conduct yourself."

Opportunities to advocate for the profession frequently present themselves, and we need to take advantage of them, whether our audience is the general public or our fellow counselors. Attending a meeting of your state counseling board is an easy step; most boards must meet in open session, and their activities are matters of public record. Public comment is usually received at the beginning of each meeting, not just when controversial items are being debated. These are free, easy opportunities for counselors to speak in a public way about issues of importance to the profession. Serving on such a board is also a very valuable way to engage in advocacy on behalf of the profession.

Clearly, there are numerous ways for counselors to engage in advocacy. Each of us should be able to identify a few ways to get involved, either based on the suggestions in this article or by staying alert to other advocacy opportunities. Whether it involves the somewhat tongue-in-cheek avoidance of the "t" word or the more substantial activity of attending a state counseling board meeting, each counselor is presented with daily opportunities to engage in the activity of advocacy.

To this counselor at least, it seems that we earn the right to express our displeasure only when we actively engage in advocacy. Not doing so contributes to some of the obstacles we currently face in attaining the respect and consideration that the counseling profession both needs and deserves. ❖

Kevin Doyle, a licensed professional counselor and licensed substance abuse treatment practitioner, is an assistant professor and co-coordinator of the counselor education program in the College of Education and Human Services at Longwood University in Virginia. Contact him at *doyleks@longwood.edu*.

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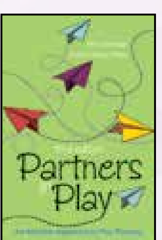

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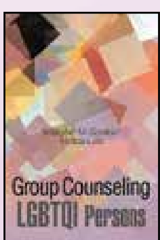

Drs. Kristopher Goodrich and Melissa Luke discuss the developmental concerns of LGBTQI individuals throughout the life cycle as they establish and maintain intimate relationships, create families, encounter career concerns, and navigate other milestones and transitions. Illustrative case examples and strengths-based interventions throughout the text, as well as cautions and recommendations, make this an ideal resource for practice.

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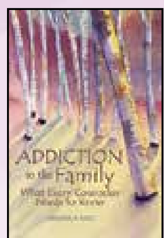

This book addresses potential clinical issues for clients who have family members struggling with addiction, and offers concrete strategies for treatment. Viewing addiction as a family disease, Dr. Kelly explores the challenges faced by family members, examines the ways in which substance use disorders affect family dynamics, and discusses behaviors that help sustain recovery and create and maintain healthy relationships. Case conceptualization exercises that contain reflections, implications for the counselor, and discussion questions for application of the material are included.

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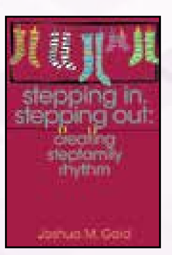
Joshua M. Gold



This much-needed resource offers insight into building and maintaining satisfying and successful stepfamily relationships. Dr. Gold emphasizes the principles and practices of narrative therapy as a means to address key concerns within the family system, reauthor dominant social myths surrounding stepfamily life, and create realistic treatment plans that are inclusive of all members of the family. Detailing the inherent strengths and challenges of the stepfamily experience, he provides an in-depth examination of the roles of each member in a blended family, including stepfathers and stepmothers, ex-spouses, grandparents, and children. This book is an excellent guide to thoughtful, practical, and empirically validated interventions for helping stepfamilies thrive.

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Member Insights – By Bronwyn Robertson

All things connect: The integration of mindfulness, cinema and psychotherapy

The therapeutic use of movies and TV shows can be a profoundly effective catalyst with even the most troubled or hard-to-reach clients

Barely able to breathe, a young man battling a panic attack hesitantly enters the group room and makes his way to an empty chair. He and a dozen others "check in" and are then guided through a simple, calming breathing exercise. The lights are dimmed and the group members are asked to focus their attention on the flickering images and pulsating sounds coming from a screen in front of them. Transfixed by these moving images and sounds, the young man's anxiety begins fading away. He is no longer in the throes of a panic attack.

Seated next to him is a middle-aged woman who has been struggling with racing thoughts and rumination. She, too, is becoming engrossed in this experience, her thoughts slowing down as she shifts her attention to what is unfolding on the screen before her. She settles into a restful state.

The group sits together, sharing this experience, for 45 minutes. Afterward, they together process what they have just experienced. All report being in better moods, much calmer and more reflective than when they first entered the room. All the group members readily agree to explore their experiences in their journals during the upcoming week and then return to share their reflections with the group.

What these group members share a week later is both unexpected and remarkable. They bring journals filled with prose, poetry and sketches. One group member struggling with an addiction shares that focusing on this homework prevented him from relapsing. A few others note that they were inspired to make major life changes during the past week, letting go of unhealthy relationships and circumstances, and even embarking on new careers. Some report having been freed of creative blocks and now being able to paint, write or compose music for the first time in months — or years. All attribute their enhanced awareness and healthy changes to the experience of sitting together in a room and collectively focusing on the same moving images and sounds.

The group didn't experience some new, groundbreaking therapeutic technology during those 45 minutes in a darkened room. Members viewed "all things," an episode of *The X-Files* television series.

The therapeutic power of cinema

From full-length feature films to episodes of TV shows, cinema engages individuals like few other mediums. Leading researchers studying the neuroscience of cinema, via the emerging field of neurocinematics, have found that when groups of people view evocative, "well-directed" cinema together, they become collectively engaged through a phenomenon known as neural synchrony. Neuroimaging studies show that the activation of specific areas of their brains and their brain wave patterns actually become synchronized.

According to neuroscientists, the human brain is wired to connect with and be activated by cinema. The iconic Swedish filmmaker Ingmar Bergman suggested that this connection might be even deeper: "No art passes our conscience the way film does, and goes directly to our feelings, deep down into the dark rooms of our souls."

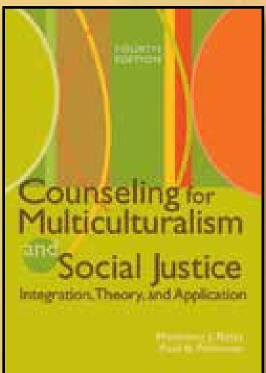
Cinema can be a powerful, transformative catalyst. As a licensed professional counselor, I have found that the therapeutic use of this catalyst, otherwise known as cinematherapy, can be profoundly effective with even the most troubled or resistant clients. While integrating cinematherapy within an experiential, mindfulness-oriented approach, I have used everything from *The Wizard of Oz* to *The X-Files* with more than 1,000 clients in individual and group therapy — with remarkable results.

Simply defined, cinematherapy is an expressive, sensory-based therapy that uses movies, TV show episodes, videos and animation as therapeutic tools for growth and healing. The clinical use of cinema has been found to enhance the therapeutic process on many levels, including strengthening the therapeutic alliance and increasing overall engagement in clients who are "difficult to-reach." As noted by Joshua Cohen, co-editor of *Video and Filmmaking as Psychotherapy: Research and Practice*, cinema has been used as a healing tool

New!

Counseling for Multiculturalism and Social Justice:
Integration, Theory, and Application, Fourth Edition

Manivong J. Ratts and Paul B. Pedersen



"This book builds on the expertise of the authors by successfully merging multiculturalism and social justice so that readers can understand the importance of bringing both counseling forces into their practices. This text takes the counseling profession to a new level, and I congratulate Drs.' Ratts and Pedersen on this important development."

—Judith A. Lewis, PhD

In this book, Drs. Ratts and Pedersen combine the very best from the multicultural and social justice traditions into a new paradigm, which will guide counselors toward a deeper understanding of the connections between these two counseling forces and how to integrate them into practice. Significantly updated and expanded from the previous edition, this fourth edition focuses on applying multiculturalism and social justice in various clinical settings with diverse client populations.

A completely new applications section contains nine chapters on working with oppressed client groups, including African Americans; Asian and Pacific Islanders; Latin@s; multiracial individuals; Native Americans; lesbian, gay, bisexual, and questioning clients; transgender individuals; women; and socioeconomically disadvantaged clients. Clients experiencing religious and spiritual concerns are discussed as well. Each of the chapters in this section provides an illustrative case study and numerous counseling examples.

2014 | 328 pgs | Order #78088 | ISBN 978-1-55620-248-3
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since its inception "because creating and watching a film often can speak directly to the human soul." What makes this medium therapeutic, he writes, is its use "with therapeutic intent within the safe environment of therapy with credentialed and trained therapists." Cinematherapy moves beyond talk therapy "by appealing to clients' visual, auditory and other senses" and offers "opportunities for self-discovery that are not found through words alone," according to Cohen.

Neuroscientist Uri Hasson, a pioneer in neurocinematics, similarly notes that the multisensory, multilayered complexity of cinema provides viewers with an experience "that evolves over time, grabbing their attention and triggering a sequence of perceptual, cognitive and emotional processes."

Evidenced-based therapy

Research spanning more than four decades has shown that cinematherapy is effective with many populations in multiple settings, ranging from outpatient to residential treatment, psychiatric hospitals to nursing homes. Cohen and his co-authors reference numerous studies in their book, including a pilot study dating back to the 1980s which found that the use of videos with 17- to 19-year-olds who had dropped out of high school resulted in enhancing their self-worth and self-esteem. More recently, Michael Powell, Rebecca Newgent and Sang Lee found the use of *The Lord of the Rings* film trilogy effective in the treatment of depression in adolescents.

Several notable international studies published in 2014 explored the use of cinematherapy within different cultures, settings and age groups. A Korean study by H.G. Kim noted the positive effects of a cinematherapy-based "group reminiscence program" on managing depression in nursing home residents. An Iranian study of "vulnerable women" receiving treatment from nongovernmental social service clinics in Tehran found cinematherapy effective in increasing self-esteem. Research from the University of Bucharest in Romania by Sorina Dumtrache concluded that group cinematherapy is effective in decreasing anxiety in young adults.

Cinema selection: Therapeutic resonance and relevance

Cinema must resonate deeply, on multiple levels, with clients for it to be effective therapeutically. The individual's age, developmental level and relationship with the cinema selection are all crucial factors. As Cohen has noted, "Movies can help clients achieve insights if the movies are strategically selected for relevance to the client's interests and needs in treatment."

To meet the unique needs of my clients, I have to give careful consideration to cinema selection. My clients, ranging in age from 3 to their late 70s, have come from diverse backgrounds and have struggled with varying challenges, including anxiety, addiction, depression, domestic violence, grief, panic disorder, social phobia, body dysmorphia, eating disorders and trauma. The selections I use are based on the specific needs, strengths, challenges and aspirations of each individual.

For instance, I have found the films *28 Days*, *When a Man Loves a Woman* and *Flight* to be particularly useful in helping adults with substance use disorders break through the denial of their addiction and gain a better awareness of the impact it has had on their lives and the lives of their loved ones. While doing a skills-based group on prevention of sexual exploitation for young women with intellectual disability, I discovered that all of the participants were avid fans of *Buffy the Vampire Slayer*, so I used an episode of the TV show to help them explore the risks of alcohol and drug use. I have also used the favorite cartoons of children in residential treatment in therapeutic exercises to enhance self-regulation and healthy attachment.

When carefully integrated within the therapeutic process, cinema has powerful healing potential. The iconic film *The Wizard of Oz* and the fantasy drama *What Dreams May Come* have long served as powerful catalysts of personal healing for my clients. With the help of these movies, they have explored core concepts of mindfulness such as resilience, compassion, acceptance and being present within oneself. Barnet Bain, the producer of *What Dreams May Come*, has noted that both cinema and psychotherapy use "the power of stories to heal." An advocate of integrative body psychotherapy, he believes that we all "take refuge" and find healing in transformational stories. "In my view," Bain explained during a brief interview with me at the Illuminate Film Festival in 2015, "any story that can lead one home to integration in the embodied present, that is a therapeutic story."

It is through the integration of mindfulness-oriented practices and cinematherapy that I have seen the most profound changes in my clients. In group therapy, for example, I integrate mindfulness-oriented exercises before and/or after viewing cinematic selections, followed by in-depth processing of the cinematic experience. I also assign homework that includes practicing and applying mindfulness skills, watching "prescribed" cinema, journaling and engaging in other expressive exercises. Follow-up sessions explore cinematic experiences via group discussion and experiential exercises, including role-play and writing or rewriting one's own script. Countless clients have reported that this integrative approach has helped them make life-changing progress.

Mindfulness, resonance and synchronicity

In my work, the therapeutic power of integrative, mindfulness-oriented cinematherapy was perhaps best exemplified by the impact that "all things" had on my clients. Unlike more typical episodes of the sometimes scary sci-fi show *The X-Files*, "all things" features no monsters, aliens or government conspiracies. Instead, it examines paths to personal transformation and investigates concepts of the mind-body connection, spirituality and synchronicity.

More than a decade ago, I was challenged with introducing mindfulness and mind-body healing concepts to clients who were court ordered for treatment because of substance use, domestic violence or related convictions. At the time, mindfulness was not yet mainstream, and very few of the people referred to me had any prior exposure to its concepts or practices. They were coming to group therapy to avoid incarceration, loss of their driver's license or removal of their children from the home. These were individuals most in need of having simple, powerful, mindfulness-based skills and concepts to better manage their lives. I needed a means through which I could introduce these concepts in a nonthreatening, entertaining and effective manner.

Initially, I showed only those segments and sequences of the "all things" episode that best illustrated core concepts of mindfulness and mind-body healing, including slowing down, paying attention, acceptance, self-compassion and the impact of toxic emotions on health and well-being. Clients were so moved by these evocative clips that they routinely requested to view the episode in its entirety.

Coincidentally, the 45-minute episode fit very well within groups that ran 90 minutes to two hours, allowing us time to engage in mindfulness-oriented exercises before or after the viewing and time to process the experience as a group and discuss homework assignments. I have now used "all things" in its entirety with more than 1,000 clients in both individual and group therapy.

Over the years, I have used the episode in dozens of different groups focusing on everything from stress management to trauma recovery. These groups have varied from eight- to 16-week structured, skills-based groups to less structured, ongoing groups for individuals with chronic mental health needs. In nearly every instance, at least one group member has reported experiencing some sort of breakthrough or making some sort of positive life-altering change after viewing "all things." In some groups, every member reported experiencing a significant impact. Many group members have noted that the episode's images and themes resonated with them on a deeply personal level. In fact, numerous clients have contacted me months or even years after completing treatment and shared that the experience of viewing this episode, in a therapeutic context, played a significant role in their recovery and personal growth.

Having watched so many clients view "all things," I have noted what moves and soothes them within this episode. Letting go of shame and guilt, seeking meaning in life experiences and "seeing the reasons why all things happen" are themes within the episode that resonate universally with clients. Grief, loss, shame, abandonment

Call for ACA Editorial Board Reviewers

The ACA Publications Committee invites you to apply for a position on the Editorial Advisory Board. This review board serves in an advisory capacity to the ACA Associate Publisher and the Publications Committee. Members review proposals for publications and other media that are submitted to ACA for possible inclusion in the publishing program. The Publications Committee considers these reviews when determining which projects will be pursued by ACA.

Selection criteria for a position on the board includes the following

- A belief in the peer review process
- A personal publishing history that includes peer reviewed scholarly publications
- Experience and skill in reviewing both print and electronic media
- Dedication to promoting multicultural competence in counseling
- The ability to meet deadlines

If you meet these qualifications and would like to participate in the process of selecting the materials produced by ACA, please note the following

- You will be contacted prior to receiving proposals to determine your availability
- Most reviews require a 2–4 week turnaround time
- You can expect to review approximately six proposals per year
- The initial term is for four years, beginning July 1, 2016, and you may be offered the opportunity to serve for a second term
- You will receive one complimentary copy of every product produced by ACA as compensation for your work on the board

Please send your vita and a letter of interest outlining your areas of expertise and publishing and reviewing credentials to:

Carolyn C. Baker
Associate Publisher
cbaker@counseling.org

The deadline for applications is May 31, 2016.
Incomplete applications will not be considered.

and exploitation are among the more personal themes that have emerged and brought tears to the eyes of many clients after watching "all things." The episode became the means through which those clients could safely identify and begin to process their painful experiences.

The use of "all things" in group therapy has had yet another surprising effect. I found that clients become much calmer and more reflective immediately after viewing the episode. In dozens of cases, I have observed clients shift out of highly anxious or agitated states while watching the episode. As a result, they were better able to reflect on and process their reactions after viewing it.

The way "all things" was directed and filmed seems to have contributed to this effect. Pulsating chimes, dripping water, ticking clocks and tapping pencils set the rhythm, while slow-motion sequences and extreme close-ups focus viewers' attention. Shots of a window shade toggle undulating back and forth, circulating fans, spinning wheels, flowing curtains, swinging signs and even the main character swaying back and forth while having a mystical experience in a Buddhist temple serve to grasp and direct the gaze of viewers.

I suspect that these cinematic devices are partly what produce an immediate calming effect on my clients, quite possibly inducing a state of mindfulness. They may even contribute to client "breakthroughs." As if they were some form of cinematic eye movement desensitization and reprocessing, could the audio and visual techniques used in "all things" produce bilateral stimulation of the brain and subsequently enhance adaptive information processing and alleviation of affective distress?

Synchronicity, neural synchrony and interconnection

Neurocinematic research may well explain some of the therapeutic power of "all things." The episode's cinematic and thematic complexity, along with its well-directed and evocative sequences, are what neuroscientists have found to contribute most to interspectator neural synchrony, or the synchronization of brain activation and brain wave patterns across viewers. Intersubject correlation (ISC) measures the collective engagement of a group of viewers via

neural synchrony. As researchers Kaisu Lankinen, Jukka Saari and Ritta Hari noted in 2014, emotional film clips enhance ISC. Likewise, "a well-directed movie," in contrast to one that is loosely structured, strengthens ISC.

According to Hasson, a research scientist and lead author of an article titled "Neurocinematics: The Neuroscience of Film," the concept of ISC is relatively straightforward and simple. "In cinema," Hasson and his co-authors write, "some films (or films' segments) lead most viewers through a similar sequence of perceptual, emotional and cognitive states. Such a tight grip on viewers' minds will be reflected in the similarity of the brain activity (high ISC) across most viewers. By contrast, other films exert (either intentionally or unintentionally) less control over viewers' responses during movie watching (e.g., less control of viewers' emotions or thoughts). Throughout the years filmmakers have developed an arsenal of cinematic devices (e.g., montage, continuity editing, close-up) to direct viewers' minds during movie watching. These techniques, which constitute the formal structure and aesthetics of any given cinematic text, determine how viewers respond to the film."

When I inquired whether inducing bilateral brain stimulation and synchronized brain activity in viewers was intentional or intuitive, Gillian Anderson, the writer, director and star of the "all things" episode, indicated that it was the latter. She explained, via personal note, that she "had no idea" that those cinematic techniques could produce such "amazing" effects. As she has noted in previous interviews, the writing and directing of the episode was a "deeply personal" endeavor and an exploration of her own deeply held belief that "we are all connected."

No stranger to counseling and psychotherapy, Anderson has both professional and personal connections to the field. She is currently penning a self-help book and has recently published the second in a trilogy of novels featuring a child psychiatrist as the main character. Personally, she began therapy at age 14 and credits it with keeping her "sane and alive." She has been a strong supporter of counseling and psychotherapy ever since.

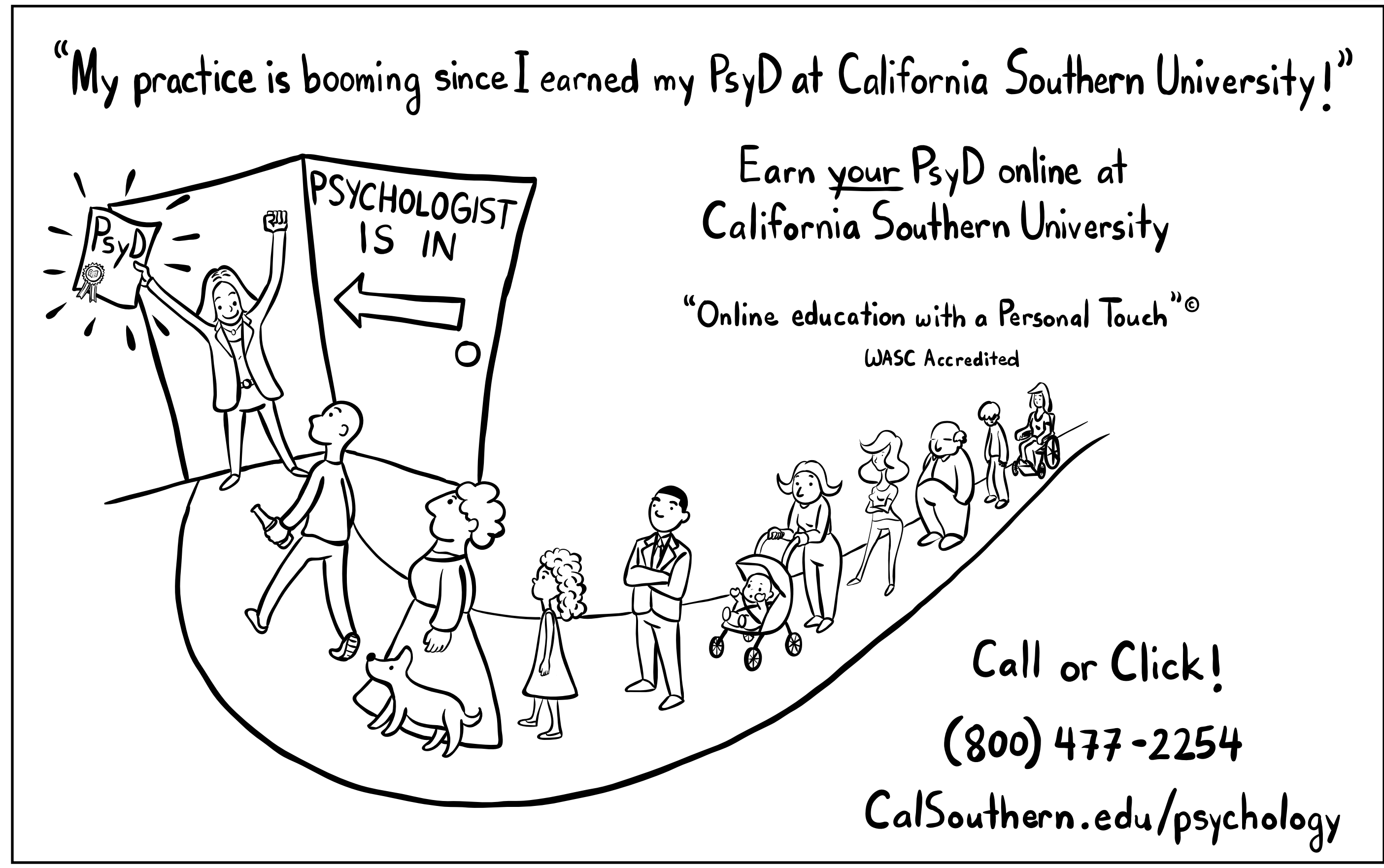
Anderson believes that cinema, like therapy, has powerful healing potential. "Any film that has a message that teaches people about themselves, that teaches people how to get out of a place where they are stuck and get on with their lives and get on with being a productive human being, is important," she said. "Films are instruments to teach people, and they can affect people in profound and in life-changing ways."

~

Note: My use of all films, television episodes, film segments and videos in group and individual therapy was done via "fair use" with no copyright infringement intended. ❖

Bronwyn Robertson, a licensed professional counselor, has lectured and published internationally on the integration of mindfulness in counseling and psychotherapy. She specializes in the treatment of anxiety, depression and trauma-related disorders. Contact her at *Bronwyn@BronwynRobertsonLPC.com*.

Letters to the editor: *ct@counseling.org*



Fiscal Year 2016 Election Results

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From the President

Continued from page 5

before I was “On the Road Again.” This time, the destination was the Windy City of Chicago. Meeting with students and faculty at Northern Illinois University (NIU) was a terrific experience. The counseling department at NIU is deeply invested in creating a training experience that will help students develop the qualities of truly great counselors. On top of that, I was literally swept off my feet on what proved to be an especially windy day.

Following Chicago, the song “Double Shot” by the Swingin’ Medallions (a beach music group from South Carolina) ran through my head as I traveled to Hilton Head for the South Carolina Counseling Association (SCCA) Conference. The conference theme, “All In: Educating, Supporting and Advocating for All Counselors,” perfectly aligned with my presidential initiative for this year on professional advocacy. Hilton Head was everything I needed after my busy travel schedule. Sharing time with my gracious and dedicated SCCA colleagues while enjoying some good old-fashioned Southern comfort was nothing short of rejuvenating.

Counselors are doing wonderful things in the world, and I appreciate the opportunity to share some of my impressions of these great works with you. Next stop, Montréal! All aboard!

All my best,
TD ❖

COMING EVENTS

ACA 2016 Conference & Expo
March 31-April 3
Montréal

The American Counseling Association is holding its annual conference and expo in partnership with the Canadian Counselling and Psychotherapy Association at the Montréal Convention Center. Preconference Learning Institutes will be held March 30-31. Attendees can earn CEs through a wide variety of timely education sessions, take advantage of powerful learning opportunities such as the Counseling-in-Action Demonstration Series, collaborate with counseling peers from around the globe, get trained to become a Red Cross disaster mental health volunteer, gain career insights and leads at the ACA Career Center, relax or recharge at special evening events and so much more. For more information, go to *counseling.org/conference*.

Law and Ethics in Counseling Conference 2016
April 3-7
New Orleans

Consider attending this national refereed professional conference that will bring together counselor educators, counseling graduate students and counseling practitioners to review the latest trends and developments in the areas of law and ethics in counseling. Details for the conference and registration information can be found at *olhcc.edu/academics/continuing-studies/*. This conference is unique in that it will be held in a retreat setting at a very low cost and will provide participants the opportunity to enjoy the city of New Orleans. Contact Ted Remley at *tremley@olhcc.edu* if you have any questions.

CCA 2016 Conference & Expo
April 22-23
Denver

The Colorado Counseling Association will hold its annual conference and expo, featuring Irvin Yalom, in partnership with the state social worker, marriage and family therapist, and addiction counselor associations at the Colorado Convention Center. Preconference trainings will be held April 21. Attendees can earn CEs by selecting from more than 100 sessions and network with more than 75 exhibitors. For more information, go to *ColoradoCounselingAssociation.org*.

CCA Annual Conference, Expo & Job Fair
April 29
Meriden, Connecticut

The Connecticut Counseling Association Annual Conference, Expo & Job Fair features special rates for American Counseling Association members. For more information, visit *ccacounseling.com*.

AHC 2016 National Conference
May 27-29
Portland, Oregon

The Association for Humanistic Counseling invites you to attend the AHC 2016 National Conference at the Portland Marriott Downtown Waterfront hotel. Enjoy a wide variety of engaging research and clinically focused presentations, training workshops and experiential learning opportunities facilitated by hundreds of counseling experts in scenic Portland. Renowned author, scholar and counselor Dee C. Ray will deliver the keynote address on "A Process of Becoming: Intersections Between Authenticity and Vulnerability in the Therapeutic Relationship." Continuing education credits will be available for registered participants. For more information on the conference and to register, go to *afhc.camp9.org*.

2016 ACA-Asia Pacific Counseling Conference
June 3-4
Singapore

The second annual American Counseling Association-Asia Pacific Counseling Conference will be held at the Suntec Convention & Exhibition Center in Singapore. The conference serves as an excellent platform for discussion between Asian and U.S. counselors. New for this year are three-hour "deep dive" skill development workshops. For more information, go to *aca-apcc.org*.

NCDA Global Conference
June 30-July 2
Chicago

The National Career Development Association Global Conference will be held at the Hyatt Regency Chicago. The theme is "Fostering Well-Being Through Meaningful Work." The event will include professional development institutes, keynote speakers, presentation series and much more. CEUs will be available. For more information, visit *ncdaconference.org* or contact NCDA headquarters at 918.663.7060.

AADA Conference
July 14-15
New York City

The Association for Adult Development and Aging is excited to host its annual national conference at the Roosevelt Hotel in Manhattan. Our proposal submission portal is currently open (the final deadline is April 15). We particularly invite proposals related to clinical practice; counselor education and supervision; research and grants; working with older adults; challenges for younger adults; and issues of diversity. Our programs will include education sessions, roundtable sessions and poster sessions. We are excited to continue offering a variety of programs covering diverse issues, best practices and research. CEU clock hours will be available. For additional information on registration or proposals, visit *aadaweb.org/conference-events/*. For questions, contact *aadaconference2016@gmail.com*.

2016 AARC Conference
Sept. 8-11
Fort Lauderdale, Florida

The Association for Assessment and Research in Counseling is pleased to announce that its 2016 annual conference will be held in Fort Lauderdale. The association invites members, colleagues, graduate students and other assessment and research specialists to attend the meeting. The conference will provide attendees with critical information regarding innovative practices and techniques, best practices for assessment and evaluation, support for graduate

student development and opportunities for networking and collaborating with colleagues. Meet us in Fort Lauderdale for sun, fun and learning. Send your questions and inquiries to Elizabeth Villares, AARC conference coordinator, at *evillare@fau.edu*.

ALGBTIC Conference
Sept. 16-17
San Antonio

The Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling is pleased to announce its second annual conference. The theme of the conference will be "Empowering Through Unity." Registration is now open and will continue until the start of the conference. Please make sure to take advantage of our early bird and membership discounts and get registered today. Visit *algbtic2ndannualconference.eventbrite.com*. Contact Adrienne Erby with questions at *algbticproposals@gmail.com*.

NARACES 2016 Conference
Sept. 22-25
Syracuse, New York

The North Atlantic Region Association for Counselor Education and Supervision 2016 Conference will be held at the DoubleTree by Hilton in Syracuse. The conference theme is "Enriching Our Professional Counselor Identity Through Dynamic Scholarship and Practice." Educators, supervisors, practitioners and graduate students are encouraged to attend. Details for the conference, the call for proposals and conference registration can be found on the NARACES website at *NARACES.org*.

WCA Annual Conference
Oct. 5-8
Casper, Wyoming

The Wyoming Counseling Association will hold its annual conference in conjunction with the Wyoming chapter of the National Association of Social Workers. The theme will be "Creating Connections." The conference will feature several well-respected speakers, including Ric Reamer, Heath Helm and eye movement desensitization and reprocessing expert Jan Schaad. In addition, the inspiring and entertaining Nancy McNenny will present "Superhero Seeks Sanity: Compassion Fatigue and Self-Care." To learn more about the conference, go to our website at *wyomingcounselingassociation.com/annual-conference/*.

FCA 67th Annual Convention
Oct. 14-15
Orlando, Florida

The Florida Counseling Association will host its 67th annual convention at the Florida Hotel and Conference Center. Preconference Learning Institutes will take place Oct. 13, with the conference running Oct. 14-15. Network with colleagues and friends at the luncheons, receptions, annual awards ceremony and our famous "Sunshine Social" after-party. Continuing education credits will be available. Register today at the advance rate to lock in the savings. For more information, visit *flacounseling.org*.

FYI

AARC congratulates award winners

The Association for Assessment and Research in Counseling is honored to congratulate several members who recently received recognition as American Counseling Association National Award winners. Thank you for your dedication to the counseling profession. ACA Fellow: Rick Balkin; ACA Research: Philip Gnilka; David K. Brooks Jr. Distinguished Mentor Award: Carl Sheperis; Don Dinkmeyer Social Interest: Dee Ray; Thomas J. Sweeney Award for Visional Leadership and Advocacy: Brad Erford; Kitty Cole Human Rights: R.J. Davis; Best Practices, Practitioner: Garry Del Conte; Samuel T. Gladding Unsung Heroes Award: Earnest Airhia.

Call for journal manuscripts

The *Michigan Journal of Counseling: Research, Theory and Practice*, the official peer-reviewed journal of the Michigan Counseling Association, is seeking submissions of manuscripts for consideration. Articles should address topics of interest using a standard article format. They may relate theory to practice; highlight techniques and practices that are potentially effective with specific client groups and can be applied to a broad range of client problems; provide original synthesis of material; or report on original research studies. Articles should generally not exceed 3,000 words. Lengthier manuscripts may be considered on the basis of content. Submission of a manuscript represents a certification on the part of the author that it is an original work. Email manuscript submissions to Arnie Coven at *aa1553@wayne.edu*.

Call for conference proposals

The Western Association for Counselor Education and Supervision is excited to announce the call for presentation proposals for its 2016 biennial conference. The conference theme is "Innovation and Collaboration in Counselor Education and Supervision." The conference will be held at the Pinnacle Harbourfront Hotel in downtown Vancouver, British Columbia, from Nov. 10-12. All attendees are encouraged to apply early for passports/passport cards. The deadline for proposal submissions is April 15. Questions can be directed to Thom Field at *tfield@cityu.edu*. More information about the conference and proposals, as well as the link for proposal submissions, can be found at the WACES website: *waces.org*. ❖

Upcoming deadlines for Bulletin Board submissions

- June issue: May 1
- July issue: June 2
- August issue: June 28

Send Bulletin Board announcements (125 words or less) to Jonathan Rollins at *jrollins@counseling.org*.

Coming Next Month

- Counseling interventions for bullying
- Navigating the quarter-life crisis
- Using client strengths in trauma treatment
- Invisible chronic illness and suicide risk

King, Mickelsen, Lane receive top marks in graduate student essay competitions

The 2016 ACA Foundation Graduate Student Essay competitions have come to a close, with three student authors being chosen as grand prizewinners: Kelly King, a doctoral student at the University of North Carolina at Greensboro; Rachel Mickelsen, a master's student at the University of Texas at San Antonio; and Robin Lane, a master's student at the University of Texas at Austin.

Student members of the American Counseling Association were competing for prizes in two essay competitions, the Future School Counselors Essay Competition (sponsored by the Roland and Dorothy Ross Trust) and the Graduate Student Essay Competition (sponsored by Gerald and Marianne Corey and Allen and Mary Bradford Ivey). Formal recognition of the winning essayists will take place at the ACA-Canadian Counselling and Psychotherapy Association Awards Ceremony on April 2 at the ACA Conference & Expo in Montréal, Canada.

Gerald and Marianne Corey and Allen and Mary Bradford Ivey Graduate Student Essay Competition

Grand prizewinners

- Kelly King, University of North Carolina at Greensboro
- Rachel Mickelsen, University of Texas at San Antonio

Runners-up

- Kadie-Ann Caballero-Dennis, North Dakota State University
- Tara Carleton, Loyola University Maryland
- Patrick Ide, Liberty University
- Heather Kramer, Loyola University Maryland
- Ketluimar Vallecillo-Samot, Liberty University

Honorable mention

- Mehmet Avci, St. Mary's University
- Sarah Davis, Marywood University
- Joshua Elliott, Eastern Kentucky University
- Gerard Grigsby, Ohio University
- Mary Rose Barbour Kaplan, Kutztown University
- Andrew Robinson, Boston University School of Medicine
- Lisa Sanchez, New Mexico Highlands University
- Nena Tahil, University of North Florida
- Ashley Tolleson, Georgia State University
- Jeff Zapor, Wayne State University

Roland and Dorothy Ross Trust Graduate Student Essay Competition for Future School Counselors

Grand prizewinner

- Robin Lane, University of Texas at Austin

Runners-up

- Alexandra Cooper, Adams State University
- Paige Haecker, Loyola University Maryland
- Rebecca Hickey, University of Saint Joseph
- Margaret Scally, Trinity Washington University
- Meg Underwood, Indiana University–Purdue University Fort Wayne

Honorable mention

- Kevon Bruce, California University of Pennsylvania
- Kimberly Crawford, Central Michigan University
- Coleen Holliday, University of Arizona
- Jessica Mason, Virginia State University
- Kevin O'Sullivan, New Mexico Highlands University
- Maureen Raj, Andrews University
- Austen Winkler, College of William & Mary

Each graduate student wrote an essay in response to the following:

The ACA Governing Council recently endorsed a revision of the Multicultural and Social Justice Counseling Competencies, which were developed by the Association for Multicultural Counseling and Development. ACA student members are asked to address what these competencies mean to them and identify ways in which they can be integrated into their formal education and eventual practice. Essayists may also speak to any challenges such integration might pose and offer solutions as to how such deterrents could be eliminated or alleviated.

KELLY KING

University of North Carolina at Greensboro

ACA's endorsement of the updated Multicultural and Social Justice Counseling Competencies (MSJCC) comes at a pivotal moment. Widespread calls for diversity inclusion and systemic change leave advocates with questions about how to do so effectively. The framework provided by the MSJCCs begins to answer these questions for the counseling community and can help us lead the change process. We have the unique and honorable mission of joining with people to promote wellness. Throughout the counseling process we engage with our clients' stories — stories informed by intersecting identities of race, ethnicity, socioeconomic status, gender, religion, sexual orientation, age, ability, and on and on. We learn

about oppression and privilege and see the tangible impact that such factors can have on the person, the family and the community. The MSJCCs offer a comprehensive set of strategies for responding to diverse clients effectively. They also encourage a life-long, dynamic process of self-reflection and challenge counselors to pursue greater open-mindedness. As a first-year doctoral student in Counselor Education, the MSJCCs reflect my passion for acting with and on behalf of my clients to effect change. I am pleased to be coming into the profession as the MSJCCs are adopted and see many avenues to promote their use.

The MSJCC domains are emphasized in training programs to varying degrees. Courses such as Helping Relationships and Counseling Diverse Populations and assignments such as constructing a genogram and pursuing cultural immersion experiences support our initial growth in cultural consciousness. This process must continue as students make initial contact with clients to introduce a focus on skills and behaviors — more concrete levels of the MSJCCs. Applying a developmental approach to these competencies suggests that we can build from our foundation of self-awareness with tangible, learning-by-doing activities. The MSJCCs offer guidelines for pursuing the attitudes and beliefs, knowledge, skills and action necessary to enact our values.

Integrating the MSJCC levels into curricula by either listing them in syllabi as course objectives or in assignment instructions as desired outcomes would help to enhance their visibility. For instance, an internship supervision syllabus could include a focus on counseling relationships skills with discussions about how counselor and client worldviews interact in session. Explicitly incorporating this domain in supervision expectations affirms the central role that culture and oppression have in our work, and strengthens the counselor's ability to work with these factors in session. This simple step could also boost our culture of approaching issues of identity and inequality.

The largest barrier to enacting the MSJCCs in training or practice may be our own lack of comfort and self-efficacy in addressing these topics. As we empower our clients, we must also empower ourselves. Openly discussing the competencies and sharing our ideas about how to act on them in session or in classrooms reinforces our ability to manage these issues. I conceptualize the MSJCCs as central to our work and would encourage our community to experiment with vulnerable self-exploration and to continue learning and defining these new, complementary skills.

RACHEL MICKELSEN

University of Texas at San Antonio

Recently, I came across a meme from an unknown author that read, "Most of the problems we encounter in life are because of two reasons: we act without thinking, or we keep thinking without acting." Similarly, the problem of privileged and marginalized counselors and clients can be contributed to these same two reasons — an unawareness of one's own attitudes and beliefs and a failure to take action when that knowledge is gleaned.

The counseling profession is only as strong as each counselor's ability to facilitate change and positive growth for his or her clients individually, within their communities collectively, and through public policy globally. The multicultural and social justice counseling competencies establish a firm foundation that every counselor should have at the core of his or her practice. As a counseling student entering this helping profession, I recognize that counselors who do not understand these competencies are essentially acting without thinking. Likewise, those who do have an understanding of the competencies, yet do nothing more than consider them, are also contributing to the perpetuation of privileged and marginalized individuals and populations.

By integrating discussion about multicultural and social justice competency issues into every course offered for future counselors and providing opportunities for self-reflection about personal beliefs, attitudes, biases, limitations, and strengths, a solid educational foundation is established. The skills then learned within those courses produce counselors with a greater capacity than merely thinking about the issues. With this approach right from the beginning, advocacy becomes more than a periphery component of a practice, but the pulsing center of the counseling profession.

The challenge of our profession is educating future counselors about removing the obstacles that prevent them from taking action — moving beyond merely thinking and talking about multicultural and social justice issues to actively advocating for them. Presenting research that empirically demonstrates the efficacy of multicultural and social justice competency practices and providing examples of counselors who are effecting change for the many by advocating for the few within their own spheres of influence will motivate and inspire the next generation of counselors to do the same.

Mahatma Gandhi said, "Your beliefs become your thoughts, your thoughts become your words, your words become your actions, your actions become your habits, your habits become your values, your values become your destiny." Through comprehensive integration of multicultural and social justice competencies into every step of the education of counselors, we are shaping the destiny of the future of the profession.

ROBIN LANE

University of Texas at Austin

The current problems facing our society seem to be growing more overwhelming by the day. It can feel impossible to effect change when our oppressive social systems are so complex and institutionalized. For future school counselors, making a difference in the world begins with helping young people overcome challenges on an individual level — but is that where it should end? According to the Multicultural and Social Justice Counseling Competencies, the answer to that question is a resounding "No."

Along with competencies in the categories of attitudes and beliefs, knowledge, and skills, the MSJCC also propose actions and interventions. Although some of these action-based competencies fit within the traditional realm of counseling — like seeking out professional development opportunities,

understanding clients' worldviews, and examining the counseling relationship — others are expected to take place beyond the individual and interpersonal level, beyond the "office setting" in which we are so comfortable. For example, counselors are recommended to "employ social advocacy," "engage in social action," and keep up to date with current events.

This perspective makes intuitive sense to me, based on my experiences in social justice work and my analysis of the world. I believe that counseling is a necessary but incomplete strategy toward bettering the lives of both marginalized and privileged clients. Many of the issues I will address as a school counselor — trauma, incarceration and deportation, sexual violence, bullying — share the root causes of racism, sexism, xenophobia, homophobia. Helping students to develop coping skills, resilience, and positive self-image makes a difference in their lives — but next year, different students will arrive with similar challenges. Why not both address the immediate pain as well as working for a world in which the sources of that pain don't exist anymore?

Not everyone sees it this way. Even the language of "privileged" and "marginalized" can be controversial. Especially for counselors who have been in the field for a long time, the concepts of power and oppression might not have been mentioned at all in their training programs. Can we fault people for not knowing something they were never taught? Perhaps this concern can be addressed in the same manner as the MSJCC themselves, by working with educating people individually as well as building the institutional structures within the ACA to better educate counselors-in-training. Another challenge concerns life-work balance. How can we find the time and energy to give 100 percent to our students and have anything left over for social justice?

A Jewish scholar, Rabbi Rami Shapiro, has powerful words to address this last worry: "Do not be daunted by the enormity of the world's grief. … You are not obligated to complete the work, but neither are you free to abandon it." The MSJCC do not make it a responsibility for counselors to end oppression, but a responsibility to try. If we all share the weight of this responsibility, our collective action has the power to heal our students — and heal our world. ❖

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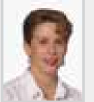

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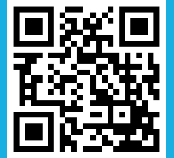

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