Treating trauma

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Cover Story

Treating trauma
By Lynne Shallcross
Counselors share their evolving understanding of trauma and offer guidance on some of the best ways to help clients reclaim a sense of safety and stability.

Features

Learning the ropes of rural counseling
By Jonathan Rollins
Rural settings offer the promise of natural beauty and a slower pace of life, but helping professionals may be caught off guard by some of the work/life challenges and unique cultural aspects that also await them.

Inviting families into the support circle
By Stacy Notaras Murphy
Even as individuals who have been diagnosed with a mental illness receive treatment, it can be all too easy for their family members to fall through the cracks.

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Lessons for counselors, circa 500 B.C.E.
By Michelle E. Flaum
The ancient Greeks can provide modern-day counselors with a helpful reminder that certain problems — and solutions — are timeless.

Reader Viewpoint
Empty chair grief work from a psychodrama perspective
By Marvin G. Knittel
The Gestalt empty chair technique has the client imagine an absent person in an empty chair; psychodrama has the client reverse roles and become the absent person.

Counseling’s role in America’s economic recovery
By Frank Burtnett
Edwin L. Herr, an icon in the areas of career development and work issues, discusses how to help American workers adjust to the profound changes confronting them.

Extras

Grad student essay competitions offer new points of view
Presenting four of the top new voices in the ACA Foundation Student Essay Contest
Help ACA provide feedback for DSM revision

Proposed draft revisions for the fifth edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) were released for public review and comment on Feb. 10. The American Counseling Association is asking our members for feedback on the proposed diagnostic criteria and content changes.

Members can submit their comments online at counseling.org/dsm by March 22. Included on the webpage are a list of important factors for counselors to consider as they review the DSM draft, as well as information about navigating the DSM-5 website.

A second way that ACA will be soliciting member feedback is through a town hall meeting at the ACA Annual Conference & Exposition in Pittsburgh. The meeting, led by ACA President Lynn Linde, will be held Saturday, March 20 at 2 p.m. in Room 413 of the David L. Lawrence Convention Center.

After comments are submitted online and heard at the town hall meeting, a task force of ACA members will compose a draft of recommendations by April 1. The task force will then send an official letter in response to the proposed DSM revisions from ACA to the American Psychiatric Association by mid-April.

ACA greatly values its members’ insights and is eagerly seeking their feedback. As the deadline to add your two cents quickly approaches, please consider offering your thoughts online, at the town hall meeting or both. Your opinion matters!

The American Psychiatric Association anticipates publishing the DSM-5 in May 2013. The last edition of the DSM was published in 1994.
Over the past several months, I have used this column to focus on issues concerning who we are as counselors, how we choose to be with our clients and others, and the gifts we give our clients. This month I want to change the focus a bit to talk about a tool that many counselors use in their practice or teaching: the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is in the process of being revised, and the draft has been disseminated for review. I want to share what the American Counseling Association has done to be responsive to the needs of our members in addressing revisions to the DSM.

I feel it is important for us to be involved in this revision activity for a number of reasons. The obvious reason is that the DSM is part of our profession. The ability to diagnose and treat mental and emotional disorders using a standard manual is part of licensure requirements in most states and, therefore, part of counselors’ scope of practice. Many of you use the DSM in your practice; others of you teach diagnosis. Use of the DSM is a cornerstone of counseling for many of our members.

The second reason has to do with advocacy. On its website, the American Psychiatric Association indicates the purposes of the DSM are to provide a mechanism for accurate diagnosis that leads to appropriate treatment and patient care, to provide a guide for clinicians and researchers, and to ensure accurate public health statistics. We need to ensure that the manual we use is appropriate for our clients and that the treatment protocols address their needs.

As soon as the draft became available for review, we decided to put together a task force to coordinate ACA’s response. Governing Council members were asked to nominate ACA members to the task force, including practitioners, students and counselor educators. From those responses and a few others, a working group was convened to review the draft DSM and write a brief report. I am sponsoring and cofacilitating a town hall meeting during the ACA Conference in Pittsburgh that will enable attendees to hear more about the revisions and provide on-the-spot feedback. A new section is being added to the ACA website (counseling.org/dsm) to provide information about the DSM revision process and our initiatives, as well as to allow ACA members to provide feedback to the task force. The task force is compiling the feedback it receives from members and will incorporate it into a report. We will then be submitting our responses to the American Psychiatric Association for consideration in the revision process.

Unfortunately, the timelines are very short between when the DSM draft was available for comment and when our final report needs to be completed. We have no control over that. However, throughout this process, we are trying to be very transparent and responsive to the needs of our members. I hope that if this is something that is important to you, you will take the opportunity to give us your feedback. I have always believed that the more input we gather, the stronger our response will be. I have tried to make this a very inclusive process. I hope we are successful.

One of our concerns in the counseling profession regards being a culturally competent counselor. How do we work with our clients to provide the most appropriate services we can within the context of their culture? The issues of diagnosis and labels are particularly problematic. The 2005 ACA Code of Ethics discusses the need to diagnose within the cultural context of the client and further states that culture impacts the way in which clients’ problems are defined (Standard E.5.b.). Therefore, we have a responsibility to do whatever we can to ensure that the manual used to diagnose clients reflects our belief that we need to view behavior within its cultural context. If we failed to do so, we would not be advocating appropriately on behalf of our clients. And to do less would be unethical.

Revising the DSM

Lynn Lunde

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Ethics Desk Reference for Counselors
Jeffrey E. Barnett and W. Brad Johnson

This pocket guide will help you interpret and apply the ACA Code of Ethics in order to prevent and resolve ethical dilemmas. In Part I, the authors provide an easily understood translation of each Standard of the Code, followed by a discussion of common challenges associated with the Standard and a list of recommendations for maintaining ethical, preventive practice in the topical area. Part II contains an ethical decision-making model and specific, practical strategies for responding to frequently faced concerns surrounding culture and diversity, confidentiality, suicidal clients, boundary issues and multiple relationships, competence, supervision, managed care, termination, and responses to subpoenas. 2010 224 pgs
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Developing Clinical Skills for Substance Abuse Counseling
Daniel Yalisove

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A Job Search Manual for Counselors and Counselor Educators: How to Navigate and Promote Your Counseling Career
Shannon Hodges and Amy Reece Connelly

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ACA Advocacy Competencies: A Social Justice Framework for Counselors
edited by Manivong J. Ratts, Rebecca L. Toporek, and Judith A. Lewis

Experts discuss how counselors, counselor educators, and students can use the ideals in the ACA Advocacy Competencies with diverse client populations, across various counseling settings, and in multiple specialty areas. Examples in each chapter provide guidance as to when individual empowerment counseling is sufficient or when situations call for advocacy on behalf of clients or their communities within the public arena or political domain. Thought provoking and engaging, this book is an invaluable resource for teaching and course work and a call for all counselors to participate in social justice and systems change. 2010 264 pgs
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List Price: $64.95  ACA Member Price: $46.95
Each April, we celebrate Counseling Awareness Month. Rather than a single day on which elected officials pass a proclamation or make an announcement at a meeting of the city council, we feel that counseling is so special, so profound and so important to society that it really deserves more than just one day and more than one single action!

On the American Counseling Association website (counseling.org), you can find a list of tips and suggestions for celebrating Counseling Awareness Month, either as an individual or as a group of professionals (or both). This is the time of year to blow your own horn. Not because you are bragging (which is also OK), but because it is critical at this time to let our society know that the counseling community is well-educated, appropriately trained and ready to help with those obstacles and life challenges faced by individuals, couples, families, teens and others. Click on our homepage link to Counseling Awareness Month, and you will be able to download “Public Awareness Ideas and Strategies for Professional Counselors.”

Here are a few ideas. Perhaps you can gather with your local group of professional counselors and plan something for April that will call attention to the good things that you do. You can volunteer to do something that demonstrates counselors’ helping nature (such as house building with Habitat for Humanity or taking a group to work at a local food bank) or perhaps provide handouts at the local mall or farmers market about how counselors can help individuals.

Some of you might choose to provide pro bono workshops at a community center or another gathering place on issues of concern to those who live in your town or city.

Also take some time to download our series of “Counseling Corner” columns that explain to laypeople what counselors can do to help their clients and students. If you are interested in these columns, go to counseling.org/Publications/CounselingCorner.aspx. Please feel free to use them in your community!

If you work in a school or community agency, let others know that your facility exists and what it is you do, even as you continue maintaining the confidentiality of your students and clients. There are many possibilities during Counseling Awareness Month for publicizing the good that counselors do. For those of you who are able to “celebrate,” please e-mail me and let me know what you did!

I want to personally thank the thousands of professional counselors who made plans to attend the ACA Annual Conference & Exposition in Pittsburgh in March. Our cosponsor, the Pennsylvania Counseling Association, has done a terrific job as our partner. From feedback heading into the event, I know that our attendees appreciate the networking, education and connections with resources that are always evident during our time at the conference. And, you know, it is never too early to start planning for next year, so I hope as many of you as possible will consider joining us at the 2011 ACA Annual Conference & Exposition that will be held March 23-27 in New Orleans!

Please contact me with any comments, questions or suggestions that you might have via e-mail at ryep@counseling.org or by phone at 800.347.6647 ext. 231.

Thanks and be well. ☃️
More thoughts on resistance

I was inspired by the excellent article on “Managing resistant clients” by Lynne Shallcross (February 2010). Finally, a discussion of “how to.” I got a lot of good insights.

I am an Adlerian and a counseling intern working on qualifying for licensure in Maryland. I have also been a certified chemical dependency counselor since 2001. That is where my experience with resistance was capitalized. Often in addictions treatment, the “family of origin” is problematic as well, so using Adlerian “early childhood recollections” is not exactly the way to garner a therapeutic relationship. Clinical labels and some therapeutic techniques are fodder for the grist (their grist, not yours) in treating many of the addicts whom I have met. They also seem to read minds when you are trying either a label or a technique on them. This brings the therapeutic process of positive change to a screeching halt.

I am also a fan of Robert Wubbolding, who was quoted in the article, and met him once at a workshop. One thing I garnered from him and reality therapy in general is that clients benefit most from “allowing.” This does not mean a haphazard path to nowhere, but rather a careful navigation, somewhat like white-water rafting. Neither of us can control the water, and we need each other to survive the current.

I particularly like the part of the article from Clifton Mitchell about knowing when to abandon the role of “expert” and recognizing when your client is self-motivated and ready for suggestion.

All in all, I like the process of change. Not long ago, a graduate professor gave an assignment to my class to pick a characteristic about ourselves that we wanted to change. He gave us eight weeks, asking us to chart the progress and apply a therapeutic model as a treatment plan. He warned us to be honest and cautioned that if we completely succeeded, he would know we had lied. I failed miserably. He was delighted with the result. He said he wanted us to be able to empathize with our clients.

Change is difficult, and our clients often have as many “emotionally compelling” reasons to behave the way they do as we have ways to help them in the process of change. As Mitchell says, we must “seek emotionally compelling reasons for change” with them. To me, that means I change a little, too.

Carol Binta Nadeem, M.A., CCDC
Maryland

“Managing resistant clients” by Lynne Shallcross is an excellent article. I would like to add another perspective and potential adjustment to assisting resistant clients.

Let’s look at resistance as a primitive safety mechanism. Every instinct pulls you back from the unknown. Resistance keeps you safe from the unknown of change. Barbara Sher in her 30 years of work has presented resistance in this manner, clarified its natural strength in keeping us safe and preventing change, and developed a strategy to work around our natural instinct of resistance. When we experience resistance, it is not laziness, failure to “want it bad enough” or guilt for inability to follow through.

We do not need to “fight” resistance (as pointed out by Ms. Shallcross). But we do need to recognize it and have strategies to circumvent its control. If we do something that is uncomfortable, tension will rise inside us. Resistance comes to the forefront sensing danger — stress. Stress is basically unpleasant and painful, and we want it to go away. So we have habits (many times, bad habits) to reduce our feelings of stress. The habits are comfortable, dulling the stress (fear, resistance). We then achieve a slight trance state (opposite of adrenal rush) and are inert.

Resistance shows a strong indication of individuality and self-determination — the intent to survive. Resistance will not go away with self-talk, by ignoring it or by shaming ourselves and forcing action. You are not capable of truly desiring to quit; you only wish to quit.

But nature left a loophole so that we can penetrate the inertia. We convince resistance we are not in danger, decrease the stress response and allow for movement (change). To decrease the control

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Locke elected ACA president

Don W.
Locke has been elected to serve as the American Counseling Association’s 60th president. He has previously served as a volunteer leader at the branch, division and national levels, including as the association’s parliamentarian in 2007-2008.

In addition to Locke, this year’s candidates were Brad Erford and Michael Lazarchick. ACA leaders and members appreciate those who were willing to run for office this year. The commitment of each of the three candidates to run demonstrates their desire to improve the profession. Fielding such a strong group of candidates lets us know that ACA is able to attract superior individuals who wish to serve.

Just under 2,600 votes were cast in this year’s election for ACA president-elect. Locke will begin his term as president-elect on July 1, 2010, and will assume the role of ACA president on July 1, 2011, for a one-year term.

Locke is currently a professor of counseling and dean of the Mississippi College School of Education in Clinton, Miss. His past leadership positions include serving as president of the International Association of Marriage and Family Counselors and the Counseling Association for Humanistic Education and Development. He was also a past IAMFC representative to the ACA Governing Council and has served on the ACA Executive Committee.

Counseling Today will publish the election results for ACA divisions and branches in the May issue.
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President Barack Obama released his administration's Fiscal Year 2011 budget request to Congress in February. The request includes a proposal by the U.S. Department of Education (ED) to eliminate a long list of specific, targeted education and vocational rehabilitation (VR) programs, including the Elementary and Secondary School Counseling Program (ESSCP), the In-Service Training Program for state VR agencies and Supported Employment State Grants. ED proposes to shift funds from these programs to a smaller number of existing programs, such as the VR State Grants Program, as well as to new, larger funding streams to spur more comprehensive education policy solutions and approaches, including a Successful, Safe and Healthy Students program focusing on school climate.

Congress will consider the president’s budget request in developing its own budget. It is unclear how popular the proposed program eliminations will be. While the American Counseling Association supports the stated goals of the programs suggested in the budget request, we are very concerned about the potential elimination of ESSCP. ACA believes ESSCP is necessary to ensure a baseline of dedicated funds for school counselors and related professionals — a key ingredient to effective education but one that is too often missing in state and local education agencies.

There is a clear demand for ESSCP. In 2009, school districts in 29 states — representing more than 850 schools and more than 429,000 students — obtained new grants to establish or expand school counseling programs and services.

ACA is working to maintain ESSCP and to ensure that school counselors are integral components of education reform. To support this effort, see ACA Call to Action on page 11 and send your school counseling success stories to Dominic Holt at dhholt@counseling.org or 800.347.6647 ext. 242.

IOM endorses independent practice for TRICARE counselors

The long-awaited Institute of Medicine (IOM) TRICARE study was released Feb. 12. ACA is pleased that the study unequivocally recommends independent practice authority for professional counselors. Congress commissioned the study to provide guidance concerning whether to remove the physician referral and supervision requirement for counselors’ services within TRICARE, the health care program serving members of the armed forces and their dependents.

ACA commends IOM for endorsing TRICARE counselor independent practice, but we also note some challenges within the recommendations. The report recommends that only those counselors who have graduated from a CACREP-accredited, 60-credit program and passed the National Clinical Mental Health Counseling Examination be recognized for independent practice. ACA recognizes the hardship this would cause for many qualified counselors and will be working with Congress to address these barriers in the course of removing the physician referral and supervision requirement from the current statute.

The full study is available on the IOM website at iom.edu/Reports/2010/Provision-of-Mental-Health-Counseling-Services-Under-TRICARE.aspx. ACA public policy staff will be analyzing the report in greater detail in the coming days at counseling.org/publicpolicy.

For more information, contact Scott Barstow with ACAs public policy office at 800.347.6647 ext. 234 or sbartstaw@counseling.org.

President’s proposal, health care summit jump-start reform consideration

President Obama and congressional leaders from both political parties held a rare daylight, televised summit on health insurance reform legislation Feb. 25. Before the summit, Obama released his proposal, which was based on the already-passed House and Senate bills and Republicans’ ideas of ways to improve the health care system. The summit focused national attention on the need for health insurance reform and expansion of coverage and gave policy-makers an opportunity to openly discuss policy approaches — and differences. The summit can be viewed on the White House website at whitehouse.gov/health-care-meeting or on C-SPAN’s website at c-spanvideo.org/program/292260-1 (part 1) and c-spanvideo.org/program/292260-2 (part 2). The president’s health care reform proposal is posted at whitehouse.gov/health-care-meeting/proposal.

The summit does not appear to have changed the procedural dynamics of advancing health insurance reform. None of the participating Senate or House Republican members expressed interest in supporting legislation to significantly increase the number of Americans with health insurance coverage, which is one of the key goals of the legislation championed by the president and congressional leaders. Consequently, House and Senate negotiators are developing a package of changes to the Senate-passed health insurance reform bill for approval in budget reconciliation legislation. House passage of the Senate’s bill, combined with both chambers’ approval of budget reconciliation legislation, would clear a reform bill for the president’s signature. Because budget reconciliation legislation can be passed with a simple majority vote in the Senate, it is a frequently used procedure for approving major legislation.

As outlined by the White House, Obama’s health insurance reform proposal would not include Medicare coverage of licensed professional counselors. ACA is working in coalition with other organizations to convince lawmakers to include such a provision in the final version of health insurance legislation changes to be approved or as part of other Medicare-related legislation. To find out how you can help in the effort to gain Medicare coverage for LPCs, visit the ACA website at counseling.org/publicpolicy or contact Scott Barstow at sbartstaw@counseling.org or 800.347.6647 ext. 234. •
Support the Elementary and Secondary School Counseling Program

Congressional leaders are beginning to hold hearings on reauthorization of the Elementary and Secondary Education Act (ESEA), last reauthorized as “No Child Left Behind” in 2001. The Obama administration’s recently released Fiscal Year 2011 budget request kicks off the annual budgeting and appropriations process in Congress, but it also provides a glimpse of the administration’s desired changes in ESEA.

The budget request includes many laudable proposals for education policy, including an overall increase in federal education funding. However, the administration is also proposing to eliminate important targeted programs, including the Elementary and Secondary School Counseling Program (ESSCP), in favor of a smaller number of larger, less narrowly focused programs. The Department of Education (ED) states the goal of these changes is to spur reforms at all levels to help the nation regain its status as the world leader in quality education, product innovation and job creation, as well as to establish ESEA programs that support all students in graduating from high school ready to succeed in college and the workplace.

The American Counseling Association believes that school counselors and related professionals are absolutely necessary for the nation to achieve these goals. Even the best instruction, curricula and leadership will not be effective if students do not come to school ready to learn.

Currently, our nation’s schools do not staff enough school counselor, school social worker and school psychologist positions to provide the comprehensive counseling programs, services and supports that students need to reach their full potential. All too often, state and local school boards leave school counseling services and personnel out of the equation. ESSCP is an important element in shining light on the critical role school counseling services can play in successful schools.

ACA is working to build a greater understanding among members of Congress and the Obama administration of the importance of these professionals and ESSCP. As part of this effort, we are urging representatives to sign a letter authored by Reps. Vernon Ehlers (R-Mich.) and Jim Langevin (D-R.I.) asking that the House Appropriations Committee fund ESSCP at $55 million for FY 2011, the same level as in FY 2010. The more representatives who sign the appropriations letter, the greater the likelihood we will secure continued funding for ESSCP and prevent its elimination during ESEA reauthorization.

ACA urges counselors to contact their U.S. representatives to ask them to sign the Ehlers/Langevin letter in support of providing $55 million for ESSCP this coming fiscal year. You can see a copy of the “Dear Colleague” letter on ACA’s Resources for School Counselors webpage at counseling.org/PublicPolicy/TP/ResourcesForSchoolCounselors/CT2.aspx.

To be effective, please personalize your letters, calls, e-mails and faxes. Share your school counseling success stories to make the case for supporting school-employed counseling professionals and ESSCP. Members of Congress value individually written communications that are written in their constituents’ own words.

Regardless of how you contact your representatives and their staffs, include your name and mailing address so the office can get back to you. Additionally, keep a copy of your contact and follow up with the office a few weeks later if you do not receive an official response from your lawmakers or their staffs. To identify your U.S. representative or to send her/him an e-mail, visit ACA’s public policy action page at capwiz.com/counseling. All members of Congress can also be reached by phone through the U.S. Capitol Switchboard at 202.224.3121.

Your individualized contacts make the difference! Thank you!

Whom to Contact
Your U.S. Representative
(not your senators at this time)
Capitol Switchboard
202.224.3121
house.gov
capwiz.com/counseling

Suggested HOUSE Message
“My name is ______, and my mailing address is ______. I am calling to ask that the representative sign on to the bipartisan appropriations letter by Reps. Vernon Ehlers and Jim Langevin in support of providing $55 million for the Elementary and Secondary School Counseling Program for Fiscal Year 2011. School counseling and ESSCP are critical for students’ health and academic success.


ACA Resource
Dominic Holt
800.347.6647 ext. 242
dholt@counseling.org
Counselor Career Stories - By Rebecca Daniel-Burke

Intersex: A life lived in-between

Some of us have been in the counseling field seemingly forever and perhaps think we have heard almost everything about all sorts of client identities and differences. But while reading the novel Middlesex by Jeffrey Eugenides, I realized I knew little to nothing about intersex. A novel is one thing, but Darlene Fike’s true personal story is amazing and, in my opinion, triumphant. Please learn from her story as I have.

Rebecca Daniel-Burke: Tell me a little about yourself.
Darlene Fike: I am an iatrogenically intersex-born transwoman. My vagina was removed shortly after birth, and while growing up, I was told I had undescended testicles and a hernia when I was born. My mother told me that the two scars I had were from when they repaired my hernia and descended my testicles.

When I went into the U.S. Air Force during Vietnam, no one blinked at my explanation. I actually did not find out the truth until after I left the military. I accidentally met someone else whose mother was in the same drug trial. I call the truth until after I left the military.

Rebecca Daniel-Burke: What led you down the path toward counseling?
Darlene Fike: I left the U.S. Air Force in 1980 with a plan of earning a master of theology degree. Shortly after entering that degree program, I became involved in ministering to those going through divorce. I found working with those individuals and families very rewarding and declared a major in marriage and family. After graduation, I returned to full-time aviation with the Air National Guard. As I prepared to retire from the military, I knew that I would enjoy returning to the field of counseling.

RDB: What is your current counseling position?
DF: I am a doctoral practicum student working at the Exchange Club in Memphis, Tenn. I am six semester hours and a comprehensive exam from being a doctoral candidate.

RDB: What is your predominant theoretical orientation?
DF: I was born. My mother told me that the one child simply as a human being. Parents need to be taught how to answer those questions. It is not easy to love your child simply as a human being.

RDB: Where does your predominant theoretical orientation come into the equation for you?
DF: Strategic, structural and solution-focused therapy. While working on my doctorate, I had the opportunity to study emotionally focused therapy with Dr. Heidi Levitt, who had trained with Dr. Leslie S. Greenberg, and I appreciate having that in my therapy toolbox.

RDB: How has your intersex experience been part of your evolution as a counselor?
DF: When I found out about myself, I wanted to find out more about intersexuality. As I learned, I realized that physicians totally controlled the process. They would sometimes cut on otherwise healthy infants without permission. At other times, they would talk the parents into having their infants cut on. The physicians who were doing the recommending were also the ones profiting from the decision. It makes me angry that they play the odds — “Well, 75 percent of individuals with this, that or the other identify as male.” OK, so what about the 25 percent who are still cut on that identify as female? Now physicians are changing the name from intersex to Disorder of Sexual Development (DSD). It does not seem like a disorder if some determine to live their lives without being cut on. I know of no intersex-born person that ascribes to the change to DSD. We are not disordered.

I then found voices other than those of physicians. Those voices talked about the exploitation of the intersexed by the medical establishment. I found it an area where I could advocate for those who are often without voices. The surgery done to otherwise healthy intersex infants is the only surgery done on one person to decrease another person’s (the parents’) anxiety. The parents need to be taught how to parent their child as a human being. The pressure comes initially with the “first question.” Is it a boy or a girl? The parents need to be taught how to answer those questions. It is not easy to love your child simply as a human being.
focused brief therapy’s behavioralistic approaches helped me survive while pretending to be as a male. I stuffed my feelings into a bag while behaving as I knew a male was required to act. I firmly believed I could act myself into a way of feeling. That bag full of pain began to disintegrate when the abuse from my childhood began to come out. The disintegration came from my summary of my earliest years in an I statement: “I will survive.”

The instructor had me to her office after class and asked me, “How bad were you abused?” While I attempted to deny it, she told me I had to get into therapy to survive the semester. I had never talked about the abuse because I knew someone would ask why the abuse happened. It happened because I was really a girl.

**RDB:** How might you start with a client?

**DF:** I prefer to find out what is on top of the stack with “What brings you in today?” The answer determines which way we might go. If I am called to a hospital setting, I usually begin with a statement of support: “You are probably feeling pretty overwhelmed right now.”

**RDB:** How did you determine what area of counseling you are passionate about?

**DF:** The first area of counseling I became passionate about was post-traumatic stress disorder. Then, after I came out, the idea of work with people struggling with gender issues became prominent. Finally, after getting numerous calls about children struggling with gender issues, I began working to include that in my practice. At this point, I would say (I am passionate about) teaching parents to love their children and to consider them blessings, not property. That also applies to the parents of those who are born intersexed.

**RDB:** Was there someone in your life who saw something special in you early on? Who valued you as a unique individual? Who is your hero?

**DF:** Dr. Catherine Addy has known me for several years and has the ability to see right through me. She automatically knows whether I need a mentor, cheerleader or drill sergeant. However, my hero in the profession is Virginia Satir. I can always reread her works.
RDB: Has studying counseling and becoming a counselor been transformational for you?

DF: Counseling has given me a vehicle for looking deeper into life, seeking to understand the person in their milieu and grasp the functionality of their behaviors, feelings and thoughts. To grasp the grit in someone’s life is transformational.

RDB: What mistakes have you made along the way to becoming the counselor you are today? And what lessons have you learned from those mistakes?

DF: When one is in the military in a position that requires clearances above top secret, that person’s life is very transparent. Counselors would describe it as a life with poor boundaries. After 32 years with the military and holding extremely high clearances, probably the biggest mistake I made was thinking life outside the military would include that type of transparency. But not everyone knows everything about each other, because you work together does not mean you are friends, and there is little if any sense of camaraderie. I miss the closeness (of the military), but I have learned to live with the distance. I just always thought of counseling as more than just a job.

RDB: Sometimes we counselors need a break from our jobs, so we try to leave it all at work. We need to read and think about other things that inspire. I wanted to ask you about what inspires you. Do you need to know about working with intersex clients?

DF: You may be surprised by them. The couple cannot have a child and comes in to see you. They are tall and good-looking. They are also grieving. There is turmoil in the relationship. The husband or wife found out that one of them has Klinefelter’s syndrome. While there are numerous causes of intersexuality, this is one many know something about.

Klinefelter’s is particularly a problem if it is the wife. One out of 500 men you meet will have Klinefelter’s, and one out of 100,000 women you meet will have that extra X chromosome. Some sources say that they are all men, but that is not what you will hear from all. Many like to play the odds with the intersexed, but we are already on the short end of the odds. If they are fundamentalist Christian, their lives may be crumbling. They may view the wife as male and the relationship as gay. The biggest issue on the front end is realizing that sex is not binary — it is bimodal. There are actually a lot of us in-between. The issues come from their pain. Treat the pain and bring in a consultant to help you understand the issues.

RDB: Is there anything I have left out that you want our readers to know?

DF: Find out as much about intersex as you can. I tend to classify anyone as intersex who has a challenge with any one of three biological issues. The first is the most obvious — external genitalia. Are they male, female or some combination? The second is not readily visible — internal organs. This can be anything from the prostate/uterus not matching the external genitals to müllerian duct anomalies, the structures in the brain or what type of gonads are present. The third I call biochemical because the issues are even less visible. The presence of certain receptors in cells, whether the body manufactures certain enzymes, how or how much of various hormones are produced and where they are produced are but a few in this category.

Darlene Fike welcomes readers to contact her at Darlene.fike@gmail.com.

Rebecca Daniel-Burke is the director of the ACA Career Center. She was a working counselor for many years and went on to oversee, interview and hire counselors in various settings. Contact her at RDanielBurke@counseling.org if you have questions, feedback or suggestions for future columns.

Letters to the editor: ct@counseling.org
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Tackling the thesis

Graduation time is near, and another round of master’s and doctoral students are eagerly preparing for the big finish. The biggest hurdle remaining for these soon-to-be graduates is likely passing an exit exam or completing a thesis. In this edition of New Perspectives, two students express concerns about the latter.

This month’s responders are:

- Debra Cobia, professor and director of the doctoral program in professional counseling and supervision at the University of West Georgia. Cobia is a licensed supervisor and counselor in Alabama and has worked for 20 years in counselor education at master’s and doctoral program levels.

- David A. Scott, clinical mental health program coordinator and assistant professor at Clemson University. Scott previously worked in a variety of inpatient and outpatient settings and was one of the directors for a large nonprofit agency serving at-risk youth and their families. He is president-elect of the South Carolina Counseling Association.

Dear New Perspectives:

It seems many master’s counseling programs do not require a thesis. I am in one such program (community counseling) but have chosen to do a thesis with the idea that it will benefit me in the future, especially if I decide to continue on to a doctorate program. Do you think this is crucial to a student’s academic development? I’m finding myself in the minority at my school in choosing to complete one. — Community Counseling Student, Pennsylvania

Debra Cobia: The research skills and knowledge needed to meet expectations for master’s-level counseling practitioners may be met in a variety of ways, one of which is the completion of a thesis. You sound as if you have given this much thought and opted to pursue the thesis option because that is consistent with your individual learning and career goals. Therefore, preparation of a thesis seems to be essential to your academic development. The same may not be true for your peers who have different learning goals that may be achieved through the non-thesis degree option.

David A. Scott: Choosing to expand your counseling knowledge base by completing a thesis can be a positive decision. Is it crucial? No. Some programs offer either a written comprehensive exam or a thesis option. In most cases, the course work is very similar, with the thesis option directed more toward research.

Your degree will probably be a master of science if you choose to do a thesis. As for whether a thesis will help if you decide to apply to a doctorate program, my answer is yes. All doctorate programs are highly competitive. Anything you can do to separate yourself from other applicants is advantageous. On the flip side, even though we (at Clemson University) do not offer a thesis option, plenty of our program’s students are accepted into doctorate programs. When students discuss with me their goal of applying to doctorate programs, I encourage them to develop research agendas that will lead to possible publications as well as presentations at state and national conferences. So even if you do not choose to do a thesis, there are typically options for research and other scholarly activities in most counseling programs that will be of benefit.

If you are questioning whether completing the thesis would help you secure a job in the counseling field, I say not necessarily. In my role as a director, I would review many applications for counseling positions at my agency. Completing a thesis was typically not part of my evaluation of applicants. Instead, a few of my top priorities were having a degree from a reputable program, passing the National Counselor Examination and having strong clinical experience.

Dear New Perspectives:

I am in a counseling psychology (community counseling track) program and am having a really difficult time coming up with a thesis topic. I would like tips on how to start brainstorming, narrowing down and choosing a topic. — Counseling Psychology Student, Oregon

Debra Cobia: First, you are not alone. For many students, selection of a topic is the largest hurdle to thesis completion. I encourage students to focus on issues that grab their interest in course assignments and readings, clinical experiences and society at large. What excites you or arouses your curiosity about the field, specific counseling practices and the people with whom you are most likely to work? Once you have identified a few broad interest areas, there is no substitute for examining the professional literature related to each topic.


David A. Scott: I remember asking a similar question when I was a student. This can seem like a daunting task, but a few issues may help in your decision making.

First, explore whether you have started to recognize themes in the papers and projects you have turned in since beginning your program. Is there a specific population or subject in the counseling field that continues to spark your interest? I remember finding that I always gravitated toward some specific topics in my classes. The more I researched, the more I realized this was going to be my topic.
This month’s spotlight is on Kirk Johnson because of his role as the Colorado Counseling Association’s graduate student liaison.

**Age:** 46

**Hometown:** Black Hawk, Colo.

**Education:** May 2010 graduate from Regis University, pursuing master’s in counseling psychology; bachelor’s in business administration from Dominican College

**Counseling employment spots:**
Owner of Creative Choices Counseling Addiction Treatment Program and intern at Maria Droste Services Counseling Center in Denver

**Greatest accomplishments:** Include receiving a Certified Addictions Counselor III Certificate; Creative Choices becoming a recognized treatment center in the mountains west of Denver; being inducted into Chi Sigma Iota Honor Society; and serving on the board of the Colorado Counseling Association.

**Biggest professional challenge:** Trying to balance family, work, school, civic duties and “me” time. Graduation is just around the corner, along with the national exam, so I can see the light at the end of the tunnel, but it is a challenge to find time to take care of myself, both physically and mentally. I recently found a great therapist for myself. I think it’s critical that new counselors find someone they can talk to.

**Words of advice:** First, be as open-minded as you can to new experiences, and do not be afraid to fail. Next, get involved in organizations. My experiences have taught me you will meet people who will be a huge part of your career and maybe your life. Finally, never stop learning. As I am finishing my program, I realize how much I still don’t know. It’s up to me to learn as much as I can in the areas that speak loudest to me.

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Second, do a thorough literature review on a few of your top choices. Find out about the current and classic research on your topic. I would encourage you to talk with your faculty about narrowing down your research. Your faculty members may also be working on similar research and could lend valuable support in deciding and setting up your thesis.

Lastly, find a topic you are passionate about. There is nothing worse than delving into a topic only to realize that you have become disinterested and not motivated to complete the assignment. Part of the thesis process is for students to really immerse themselves in a topic. They can do this best when they are excited about the topic, eager to learn and motivated to discover new and existing ideas about their topic. Another key benefit of being excited is that it will make the process of writing a thesis less painful — and maybe even enjoyable! •

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Donjanea L. Fletcher is the column editor for New Perspectives and a student affairs counselor at the University of West Georgia. If you are a student or new counseling professional who would like to submit a question or an article to this column, e-mail dfletche@westga.edu.

Letters to the editor: ct@counseling.org

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Try to balance family, work, school, civic duties and “me” time. Graduation is just around the corner, along with the national exam, so I can see the light at the end of the tunnel, but it is a challenge to find time to take care of myself, both physically and mentally. I recently found a great therapist for myself. I think it’s critical that new counselors find someone they can talk to.
Making the most of electronic mailing lists and interest groups

What's a good book for an 11-year-old boy going through his parents' divorce? How can you find a lesbian/gay/bisexual/transgender therapist who specializes in couples issues? Is there a psychiatrist on the north side of town who takes CIGNA insurance and is accepting new patients? How can you stay abreast of trends and changes in your specialty? What billing software are other therapists using? Where can you find different models for dealing with bullies? How do you get a recommendation for an attorney and an accountant who are knowledgeable about counseling and private practice in your state? Did Blue Cross/Blue Shield change the precertification process for counseling? How do you market your parenting workshop to other therapists? Where is there a local social service agency that has a sliding fee scale and provides dialectical behavior therapy?

For answers to these and other questions, consider tapping into your colleagues' knowledge on electronic mailing lists and within interest groups. In many instances, these resources can provide the professional counselor in private practice with a wealth of information quickly, all without leaving the office. (Note that many people use the term LISTSERV to generically refer to any electronic mailing list, but LISTSERV, which was the first e-mail list software application, is a registered trademark.) You can find these great resources through groups.yahoo.com, by asking other professionals in your area or by contacting your state counseling branch, professional societies and national associations. What could be easier?

A number of years ago, we were referred by a colleague to the Chicago Therapist LISTSERV. Even though I (Norm) live 65 miles west of the city, the e-mailing list is an invaluable private practice tool. I can ask a question; see what other therapists recommend in terms of services, products and best practice; announce the dates of our private practice workshops; learn of referral sources … the list could go on and on. By joining the e-list, we can tap the knowledge and expertise of more than 650 counselors, social workers, psychologists and other providers with a single e-mail or simply sit back and read the advice and opinions being offered by other therapists.

Can't find an e-mail list for counselors in your area? Start one! It's easier than you think. We spoke with Karen Ross, owner and moderator of the Chicago Therapist LISTSERV, about what's involved. She suggested the following steps:

1) Choose a domain where the e-mail list will be housed. Ross uses Yahoo! Groups. Go to groups.yahoo.com and click on “Start your group.”

2) Choose a specific shared interest for your group name and goal. Ross chose Chicago Therapist because she wanted to network specifically with psychotherapists in the Chicagoland area.

3) Decide the role you are going to play. Do you want to moderate the group? If so, to what extent? Perhaps you want to recruit members to join you in the ongoing responsibility of managing membership requests, fielding questions, reminding participants about guidelines and so on.

4) Create guidelines for your group. Ross prefers to have group members assist in providing a more democratic and connected feel to the experience we share as a community.

5) Invite as many people as you can to join the group. Use your resources. E-mail colleagues and pass out informational sign-up sheets at continuing education events. Be open with your excitement about the group. Talk about your group with other colleagues you meet. “Eventually, over time, more people came to me requesting membership rather than me hunting down new members,” Ross says.

“I remember being excited when we had 30 members, and now we are approaching 700. It really is an ‘if you build it, they will come’ type of thing.”

According to Ross, expect to devote a few hours per week to monitoring the e-mail list and working with membership issues. This is a good practice-building strategy and a great way to give back to the profession. For more information, contact Karen Ross, a licensed clinical social worker, at firehead4@aol.com.

If you want to connect and network with other counselors on a national level, David Kaplan, chief professional officer for the American Counseling Association, suggests the following e-mail list groups:

- CESNET for counselor educators
- International Counselor Network (ICN) for school counselors
- DIVERSEGRAD for those interested in counseling topics related to multiculturalism and diversity
- COUNSGRADS for graduate students in counseling
- ACESGS for doctoral students in counseling (for information on accessing this group, go to the “Student” section of the Association for Counselor Education and Supervision website at acesonline.net)

Interest networks are another way to stay connected with the global counseling community. Holly Clubb, ACA’s director of leadership services, notes that ACA has the following interest networks:

- ACA Interest Network for Professional Counselors in Schools
- Animal Assisted Therapy in Mental Health Interest Network
- Children’s Counseling Interest Network
- Forensic Counseling Interest Network
- Grief and Bereavement Interest Network
Q: Thank you for the volumes of information you provide to ACA members. I’m preparing to start my private practice and would like to have a fully paperless office utilizing a web-based charting system and a scanner to capture all documents received in paper form. I am fully competent in the technological aspects of this plan, and all electronic files will be maintained with multilayered security, including password protection. It seems this would be HIPAA-compliant and ethical, but a licensed professional counselor in my area (Michigan) told me she thinks we are required to retain the originals of some documents no matter what. Could you share your insights on the paperless practice?

A: Congratulations on your decision. We think paperless is great. We know of no reason for paper backup unless an agency has a policy to that effect. If someone is worried that data may be lost because of computer failure, back up everything on a flash drive that is password protected.

Consider these systems that we have found or that readers have recommended. All have paperless capabilities.

EZClaim (ezclaim.com/products.php) seems to do all that you want — sends claims, receives reports and autoposts payments. It has a beginner’s guide (ezclaim.com/edi-beginners-guide.php) that is a great reference on the basics of electronic billing.

As for paperless charting, NextStep Solutions (nextstepsolutionsinc.com) has “paperless applications that are compatible with EZClaim Advanced. NextStep features custom assessments, case management, budgeting, seamless billing with EZClaim, treatment-planning wizard, charting and integrated scheduling with EZScheduler. NextStep was conceived by mental health practitioners, technology experts, businessmen and women.” Bob Walsh knows and uses this option.

The following systems have also been recommended. They have paperless applications and, as good programs should, all offer a free trial.

Therapist Helper (helper.com) is mentioned frequently as an all-in-one program.

Office Therapy and QuicDoc, made by DocuTrac Inc. (quicdoc.com/index.htm), is highly recommended by one of our readers, licensed professional counselor Philip Koestler. They offer electronic billing, charting and a function that allows you to process credit cards.

You can also find paperless applications in many other programs. As with any program, know all the fees beyond the purchase price for add-on components, tech support, licenses, renewal, multiple users, updates and so on.

Our schedule of upcoming private practice workshops:
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April 26, Ann Arbor, Mich.
April 27, South Bend, Ind.
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Sept. 18-20, New Orleans
For details or to register, visit counseling-privatepractice.com and click on “Seminars.”

ACA members can e-mail their questions to Robert J. Walsh and Norman C. Dasenbrook at walshgasp@aol.com and access a series of “Private Practice Pointers” on the ACA website at counseling.org.

Letters to the editor:
ct@counseling.org
Creating Spiritual and Psychological Resilience: Integrating Care in Disaster Relief Work

If you are a mental health or spiritual care professional who either plans to become involved in disaster relief work or wishes to expand his/her capacity to respond, this is definitely a book you will want to read. The editors have pulled together authors from a variety of professions (mental health, medicine, theology, communications, management, anthropology and so on) for chapters that provide essential information both to professionals who may be novices regarding disaster relief work as well as those who are seasoned veterans. The chapters are well written and provide perspective on the book’s theme, which is advancing collaboration between spiritual care and mental health disaster response for the purpose of increasing the quality of care provided to those who have been negatively impacted.

In the first section of the book, the authors lay a foundation for taking an interdisciplinary approach, which they argue is necessary to best meet the post-disaster needs of people who have been traumatized. The authors make use of anthropology and ethnographic perspectives, forcing those who may have varied experiences to look at the overall response from a broader perspective. Although it is true that all trauma is, in the final analysis, an individual experience, this approach suggests that a myriad of factors go into any individual’s experience. These factors can be very beneficial if capitalized on during any kind of relief operation.

The second section offers several scenarios of disaster response from a collaborative perspective, showing concretely how this broader view and comprehension of a more all-encompassing response, both organizationally and individually, has the potential for increasing the good of the cause. In addition to increasing quality assurance relative to the response, a multidisciplinary disaster relief operation diminishes both the psychological and financial impact on a community as well as on individuals. By respecting one another’s contributions, government, nonprofit agencies and religious organizations can reduce the real costs of recovery and accelerate the journey back to a more normal state of affairs.

In the third section, the authors discuss ways to nurture resilience among the people impacted by disasters. The rituals and routines we possess as individuals are vehicles that can be very facilitative as we struggle to make sense of what we have experienced following a disaster and how we will be. The two distinctive perspectives of vulnerability and resilience in retraumatization are compared as the authors discuss the essential approach of providing a continuum of care that spans as many of our collective human variables as possible.

Reviewed by Howard B. Smith, interim dean and professor emeritus, South Dakota State University (retired).

Foundations of Counseling and Psychotherapy: Evidence-Based Practices for a Diverse Society

Times are changing. Accountability, evidence-based counseling and best practices are terms clearly coming to the fore. Insurance companies, mental health facilities and hospitals are demanding a more outcome-based, scientific approach. This emphasis is now coming to schools, university counseling centers and counselor education as well.

A number of programs accredited by the Council for Accreditation of Counseling and Related Educational Programs are meeting this challenge by moving toward transformational curricular experiences
while retaining social justice, multiculturalism and the wellness perspective across the developmental life span. What is unique about these programs is that they are preparing for a new future while simultaneously keeping the best of past traditions.

David and Diane Sue’s text, *Foundations of Counseling and Psychotherapy: Evidence-Based Practices for a Diverse Society*, is designed to meet these new challenges. Rather than a “theory of the week” approach, the Sues focus on “what works” and what beginning professionals can do to meet the demands of the changing mental health scene.

This book presents evidence-based approaches (which are often controversial) in a new, scholarly, interesting and even comforting way. In the process, it provides an excellent transition from the past to the present. As just one important example, critical data on empirically supported relationship variables are presented. There, students and professionals will find once again that relationship/therapeutic alliance, empathy and collaboration remain vital. Evidence is clear that 30 percent of successful counseling and therapy depends on these relationship variables, and Chapter 3 focuses on these dimensions in depth.

Let’s look at how the rest of this book is organized for a comprehensive new approach to a counseling theories course. Using the behavioral objectives language, I would say that students (and professionals) who utilize this book will:

- Gain a solid understanding of the strengths of evidence-based practice and the vitality of bringing back a scientific approach to our profession
- Be able to engage in collaborative assessment and diagnosis in a social/environmental context, thus placing client and counselor on a more egalitarian base
- Understand and practice the most frequently used modes in counseling and clinical practice: psychodynamic theory and techniques, core conflictual relationship therapy, interpersonal, motivational enhancement and, of course, cognitive behavioral therapy
- Apply clearly effective, evidence-based approaches to that common issue we all face with our clients — depression

- Develop skills and strategies in multicultural and diversity counseling (in two excellent chapters)
- Learn a basic framework for intake and crisis counseling
- Generate a beginning familiarity with psychopharmacology and medications

This resource could serve as a different textbook for the theories course — one with important and practical implications for the future. I recommend it most highly.

Reviewed by Allen Ivey, distinguished university professor (emeritus), University of Massachusetts, Amherst, and courtesy professor of counseling at the University of South Florida.

Ruth Harper is the column editor for Resource Reviews and a professor of counseling and human resource development at South Dakota State University. Contact her at Ruth.Harper@sdstate.edu.

Letters to the editor: ct@counseling.org
Choosing a career is one of the most important decisions a person makes—a decision that often is made not just once but several times throughout the individual’s life. Career theorists describe different elements and suggest various approaches to making career decisions, but in the end, it seems that we fall back on the basics: knowledge about self, knowledge about options and decision making.

Career assessments

The first requirement of effective career decision making is having accurate knowledge about one’s unique capabilities, interests, values, goals and so forth. While inputting terms such as career test or career inventory into a search engine will yield thousands of free links, buyer beware. Many times, you get what you pay for. Once a career decision is made, significant time and energy is invested in gaining the skills and knowledge to prepare for that career. In other words, why make such an important decision based on information that may be invalid or unreliable?

- Career Decision-Making Difficulties Questionnaire: tinyurl.com/yzj4stv
- O*NET Skills Search: tinyurl.com/4utyj3
- O*NET: online.onetcenter.org
- The Career Key: tinyurl.com/ycxpnol
- Self-Directed Search: tinyurl.com/dbx9og
- Campbell Interest and Skill Survey: profiler.com
- Kuder Career Assessment: kuder.com
- Skills Profiler: tinyurl.com/yaixnt
- Vocopher (contains many inventories for career professionals): vocopher.com
- University of South Florida Career Resource page (assessments): tinyurl.com/y2w8vpm
- Do’s and Don’ts With Career Assessments: tinyurl.com/y9e84w

Occupational information

A second key component for effective career decision making is valid, reliable information. Some commonly used sources for occupational information include:

- Occupational Outlook Handbook: bls.gov/oco
- O*NET: online.onetcenter.org
- America’s Career InfoNet (includes videos): acinet.org
- CareerVoyages: careervoyages.gov
- CareerOneStop (state-specific information): tinyurl.com/yzd9erd
- University of South Florida Career Information page: tinyurl.com/ya4rb6a
- Career Guide to Industries: bls.gov/oco/careers
- Military careers: todaysmilitary.com/careers
- Translating military occupations to civilian occupations: tinyurl.com/y8ux9yp

In addition, to find up-to-date information about occupations, a counselor might suggest researching current job openings to learn what skills, training and experiences are currently in demand for a position of interest, as well as associated salary ranges. Some popular job search sites include:

- CareerBuilder: careerbuilder.com
- Monster: monster.com
- Snag a Job: snagajob.com
- USAJobs: usajobs.gov

Decision making

Once individuals have determined they have enough information about themselves and occupations of interest, the next step is to use that information to make initial career decisions.

- The Career Decision-Making Tool: tinyurl.com/yfob6ys
- Quintessential Careers (a plethora of articles and career tools on decision making): quintcareers.com
- Understanding the “what” and “how” of making a career decision: tinyurl.com/yhxwpv2v

Turning information into personal assessment

Occupational titles change rapidly, and some are so specific that they won’t be found on the list of occupations provided by any assessment. A counselor can use information from career information sites or current job notices to create a personal self-assessment. For example, consider that a client is interested in learning about becoming a fuel cell engineer. General information is available on O*NET, but there is also a note stating that more research is being conducted on this occupation. A quick search on the Internet yields many job postings that can then be translated quickly into the self-assessment pictured on page 23.

If the client is very interested in the career but missing key experiences or skills, the counselor can create a personalized career plan by adding a fourth column for “next steps.”

Similarly, a counselor can quickly create a specialized card sort specific to a client’s general area of interest. For example, consider a student who is interested in medical careers or artistic careers. A counselor can do a search on artistic occupations or medical occupations, print the list on card stock paper and then cut the cards along with the headers (Would Choose, Wouldn’t Choose or Might Choose). The client sorts the cards into piles under the headers and prioritizes the cards within the “would choose” pile. Together, the client and counselor determine what the next steps might be, such as seeking more in-depth information about the occupations in the
“would choose” or “might choose” piles, exploring training/educational programs or talking with individuals in those fields. Sample card sorts can be seen at tinyurl.com/yfln4g.

Professional associations
Professional associations can provide additional information on career resources and links, as well as information on how to locate a career counselor.

- National Career Development Association: ncdca.org
- National Employment Counseling Association: employmentcounseling.org/
- America’s Career Resource Network: cte.ed.gov/acrn
- Association for Assessment in Counseling and Education (includes a link to standards for multicultural assessment): tinyurl.com/ygcxyyk

Summary
Having access to quality information about self and options is key to making an effective career decision. A variety of tools have been presented in this article to help with that process. While many people can make use of these tools without the aid of a counselor, some may prefer to have a professional trained in career counseling to help them navigate through the career decision-making process. To read more about choosing a career development professional, visit tinyurl.com/yyxw936.

Debra Osborn is an associate professor and coordinator of the career counseling program within the counselor education program at the University of South Florida.

Letters to the editor: ct@counseling.org

The very popular fifth edition of the Study Guide for the National Counselor Exam (2006) has 350 pages and covers the eight content areas of the National Counselor Exam, national comp exams (CPCE) and many similar exams. The Workshop DVDs contain over 6 hours of an actual workshop focusing on: Appraisal, Research, Professional Orientation, and Career. The other four areas are covered lightly as well as test-taking strategies and study tips.

The Study Guide costs $79.95 and the Workshop DVDs are $69.95. Save $20 by purchasing them at the same time for $129.95. Prices include all mailing and handling costs. Order at website: www.counselor-exam-prep.com. Email: ahelwig@sprintmail.com for more information.
The miracle list

Some brief therapy techniques have helped my practice to become much more efficient. The one I use the most is the “Miracle” list that I create with my clients in the first or second session.

This is how I introduce the concept: “I’d like you to envision a miracle. And the miracle is that suddenly (because you wake up or you sneeze or something), your life has become perfect. It is exactly as you would like it to be. Then how would you know that the miracle happened? What would be different so that you knew the miracle had indeed happened?”

I then list each item my clients identify. I write each of the “miracle” items, one per line, in the present tense of what would be (as opposed to what wouldn’t be) and in a way that my clients have control over achieving the items (i.e., “I feel happy”). I also mention to them that we can add items to the list anytime they want to do so.

After the list has been made, I ask four rating questions (1-10 scale, 1 low and 10 high) of them:

“How much do you want this miracle?”
(Not is it feasible or who has to do what or how much time it will take. I am simply asking about “want.”)

“How much confidence do you have that this miracle is actually possible?”
(Not probability or likelihood, just “possibility.”)

“How willing are you to do your part to make this miracle happen?”
(Not a guarantee or commitment, just “willingness.”)

And, finally, “If 1 represents the worst your life has been concerning these items and 10 means that the miracle has been achieved, where are you today?” (After I have received a number from them, I then ask them what they have done to bring them from a “1” to where they are today. It helps my clients to realize it was not because of circumstance or what someone else has done — they did it. They have the power to improve themselves and make their lives better.)

Then I ask about who has the control to make each item happen (if I have written them well, nearly all of the items will end up being in the control of my client). I then ask the clients to rate where each item is today in order to give us a baseline from which to work. I then summarize what we have done — where the control lies in order for each item to be accomplished; each of the rating numbers indicating their desire, the possibility of it being accomplished, their willingness and their progress already. I add my observation of the strengths they possess that they have shown me already and my confidence in their being able to achieve this miracle.

My clients generally leave this session feeling empowered and encouraged, knowing that their “miracle” is actually possible to achieve and they are already on their way to getting it. I close the session by giving them homework (to be completed by the next session) of keeping their eyes on the miracle, doing what they know how to do already and bringing to the next session what they don’t know how to do but most want to learn how to do. (That item will be the focus of our next session.)

This miracle list serves several purposes.

1) It identifies very clearly for the client and for me what the client’s goals of counseling are — it removes the guesswork for us both. Some clients believe they don’t know what they want, but by completing this list, they prove to themselves that they indeed do know very specifically what they want.

2) It empowers my clients so they see that each item is either within their control or it is not something we are going to spend any time on in session because it would be a waste of time.

3) It identifies for them what they want, not just what they don’t want. It helps them to be focused on, and trying to achieve, the positive, not trying to avoid the negative in their lives.

4) The clients can take home a copy of the list and post it in a conspicuous place as a reminder to stay focused on their wants. This list gives the clients something tangible to keep in their view, day after day.

5) The list gives us a starting point from which to gauge clients’ progress. We can rate their progress every few sessions in order to help them see how far they have come since last recording and since the beginning of our time together.

6) If the clients come in without any particular item on which to work, I look at the miracle list and refresh their memories of what they initially identified. After reading the list, if there is an item on the list that jumps out at them or one that we have not yet addressed, it is a wonderful option for us to consider for that session.

7) By updating the ratings on this miracle list, it shows the clients and me when they are nearing completion — there aren’t any surprises for them or for me.

This brief therapy tool has helped me be more efficient and successful. My clients have expressed appreciation for having this concrete device to help them progress and stay focused on their therapy goals. The impact that this one tool has had on my clinical practice has been nearly miraculous!

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In just the first two months of 2010, devastating earthquakes rocked Haiti and Chile, a University of Alabama in Huntsville professor stood accused of gunning down colleagues at a faculty meeting and a reportedly disgruntled pilot flew his private airplane into an Internal Revenue Service building in Austin, Texas. These tragedies ranged in scope and affected people in different states and countries, but one common denominator was the trauma they no doubt left in their wake.

Natural disasters, ongoing wars, terrorist attacks, plane crashes, school violence and abuse are among the most widely recognized causes of trauma, but one expert points out that trauma can also stem from events that don’t necessarily make the national news. “Every day, counselors work with clients who are exposed to or experience the tragedies of daily life — auto accidents, the sudden loss of family members, friends, classmates or coworkers,” says Jane Webber, associate professor at New Jersey City University and coordinator of the university’s counseling and school counseling program. “Where we once considered traumatic events as rare, we now know that most people experience one or more such events in their lifetime.”

Carlos Zalaquett remembers working with a 64-year-old client who was referred to him for treatment for depression. “While discussing her history and intake form, she mentioned that she had felt depressed and anxious for the last four years,” says Zalaquett, coordinator of the clinical mental health counseling program and the graduate certificate in mental health counseling in the University of South Florida Department of Psychological and Social Foundations. “She didn’t have a prior history of these symptoms, but her family believed that aging and lack of a support or social network led to her current situation.”

As the two explored the woman’s strengths and therapeutic goals, the client shared with Zalaquett the goal of driving her car again. “Upon exploring the reasons for mentioning this goal, which was somewhat puzzling to me, she reported surviving a near-death car accident four years prior,” says Zalaquett, a member of the American Counseling Association. “She described living a life encompassing all of her current therapeutic goals, including driving her own car, before this traumatic crash.”

The focus of treatment rapidly shifted to addressing the client’s post-traumatic stress reaction following the accident, Zalaquett says. “We used systematic desensitization, imagery techniques and in vivo exposure to help her reduce her fear of driving and get her in the driver’s seat. Four months later, she was driving and, much to the surprise of her family, was no longer clinically depressed or anxious. She had reestablished a connection to a social network of friends and acquaintances.”

The root of the problem
While the causes of trauma can vary widely, Zalaquett says, it is important to...
include sleep disturbance, emotional
associated with trauma-induced stress
into this category, Webber says. Ongoing harassment or bullying can fall
physical abuse, domestic violence,
complex traumas such as sexual and
by the ACA Foundation. Individual
dition of which was recently published
Mascari, served as editor for Terrorism,
Webber, who, along with J. Barry
learn about the unexpected or violent
death of, or serious harm or injury to,
a family member or close associate, he
adds.
There are many traumatic events that
do not meet the criterion of threatened
death but are like ‘living death,’” adds
Webber, who, along with J. Barry
Mascari, served as editor for Terrorism,
Trauma and Tragedies: A Counselor’s Guide to Preparing and Responding, the third
edition of which was recently published
by the ACA Foundation. Individual
complex traumas such as sexual and
physical abuse, domestic violence,
ongoing harassment or bullying can fall
into this category, Webber says.

Some of the signs and symptoms
associated with trauma-induced stress
include sleep disturbance, emotional
instability and impaired concentration,
Zalaquett says. When people have
become emotionally or psychologically
overwhelmed, they often protect
themselves through denial, disbelief
and dissociation, he adds. Traumatized
individuals can have difficulty performing
regular duties, might experience
flashbacks or nightmares and may
respond to events that remind them of
the trauma. “Flood victims, for example,
may demonstrate very strong emotional
responses to rain, storm clouds, the sound
of running water or the sight or smell of
mud,” he says.

Zalaquett says counselors should also
be aware that clients might express their
emotional distress physically, complaining
of headaches, backaches, stomachaches,
sudden sweating or heart palpitations,
constipation or diarrhea, or susceptibility
to colds and other illnesses.

But the signs of trauma aren’t always
visible, Webber says, so counselors should
remain patient and supportive. “I have
often worked with clients who, although
they have been to several therapists, have
never disclosed their symptoms or their
trauma history,” she says. “Being fully
present in the moment with such a client
helps to build a safe environment. It may
be weeks or months before the client feels
safe enough with the counselor to disclose
even a small hint.”

Presenting problems, intake forms
and case histories can provide clues
to a client’s traumatic experiences,
says Webber, a past chair of the ACA
Foundation who teaches disaster
response, trauma and crisis counseling.
“ Asking solution-focused questions
helps. For example, ‘When was the last
time you felt good? When do you not
feel this way? What are you doing when
you feel differently?’ With training
and supervised experience, counselors
often develop an intuitive feeling about
traumatized individuals — a sixth sense
about the client’s fears, terror, feelings
of being threatened and resulting self-
protectiveness. The counselor ‘feels’ as
the client feels and is alert to triggers that
increase symptoms like hyperarousal,
hypervigilance, dissociation, numbing,
help to build a safe environment. It may

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Counselors strongly emphasize the importance of helping clients understand that the feelings they are experiencing after a traumatic event are completely normal. But according to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, when post-traumatic stress symptoms persist for at least a month, a diagnosis of post-traumatic stress disorder (PTSD) might be considered. “For individuals experiencing PTSD, many emotional and cognitive processes become more intense, while paradoxically, others are deadened,” Zalaquett says. “In a sense, individuals who have their lives suddenly and drastically changed by destructive events essentially experience more than they can integrate, and their feelings of personal control, competence, security and safety are all greatly diminished. They now view the environment — and to some extent, other people — as unsafe. On guard, they are ready for danger at all times. This state of hypervigilance also increases the likelihood of social withdrawal and isolation and decreases the likelihood these individuals will seek assistance for their distress.”

Not everyone exposed to a traumatic event develops PTSD or other serious disorders, however. Webber notes studies have shown that the majority of people in mass disasters experience personal and spiritual growth and create new existential meaning as a result of their experience.

Certain trauma tasks are time sensitive, Webber says, such as securing an individual’s immediate physical and emotional safety, whether in the aftermath of an earthquake or in a situation of child sexual abuse. “Research shows that when survivors of mass disasters receive psychological first aid, this speeds the return to normal functioning,” she says. “Psychological first aid also provides for identification and referral for additional support for those with predisposing conditions or more serious problems.”

In disaster situations, many counselors want to begin providing counseling immediately, but doing so may have unintended negative consequences, the best approach is to ask and trust the client’s process.”

Webber agrees that establishing safety and stability for clients, not only in the therapeutic session but also in their lives, should be first and foremost for counselors. After that, Webber recommends a variety of helpful techniques:

- Use metaphors that can be seen, heard and felt to help clients become attuned to where distress is felt in their bodies, she says. For example, have the client visualize the trauma as a pressure cooker with the toggle shaking and ready to blow.

- Use grounding techniques to help clients stabilize. For example, Webber says, ask clients to name five non-distressing objects they can see, five non-distressing objects they can hear and five non-distressing objects they can touch. Integrate this exercise with deep breathing.

- Try multisensory materials in sand play, play therapy, drama and art therapy. “I find that sand play integrates touch, seeing, hearing, smelling and even tasting,” she says. “Choosing miniature figures and objects that appeal to you and creating a scene in the sand is very powerful.”

- Consider eye-movement desensitization and reprocessing therapy and brainspotting. “(A counselor) must have training, but I can’t imagine trauma treatment without these brain-based power therapies that reduce flashbacks and intrusive memories quickly,” Webber says.

- Use drama. “Psychodrama offers a kinesthetic multisensory modality for clients to express their feelings and act out their sensory traumatic memories,” Webber says. “It provides a way to talk about trauma and one’s reactions in a symbolic way that is not as fearful as traditional talk therapy.”
Have the client make a scene in the sand or draw a picture of something scary and then talk about feelings. “Then do whatever you want with the picture to get rid of the feelings,” she says.

One major difference in treating trauma as opposed to other issues is that the potential for primary or secondary traumatization and compassion fatigue in counselors is very high, Webber says. “Counselors’ greatest asset is our empathy. It is also our greatest liability. Counselors may show signs of traumatization, experience fear and pain and personal distress by their exposure to the client’s trauma story.” Counselors can combat compassion fatigue and traumatization in part by developing and following through with a self-care plan and by taking time for rest and relaxation, she says.

Treating trauma can also resurrect a counselor’s own traumatic experiences, Webber says. She recommends that counselors do their own trauma work with a trained therapist before working with others. If counselors are impaired or vulnerable, she adds, they should refrain from treating trauma clients.

Those risks aside, through her years of treating trauma, Webber says her faith in humanity and in counselors’ ability to help has been strengthened. “Trauma is the ultimate existential challenge to continue living in spite of horrendous and unspeakable pain and sorrow. We are all in this world to help each other. Our greatest tool is our person, and our greatest gift is to walk with someone on his or her path to recovery.”

Helping the helpers
When it comes to the relationship between first responders and trauma, Brian Chopko says guilt plays a leading role. A counselor and assistant professor in the Department of Justice Studies at Kent State University at Stark, Chopko vividly recalls one client in her early 50s who responded to an emergency but ultimately couldn’t save the lives of two people. “She tried so hard to save them that she was almost killed herself,” says Chopko, explaining that the first responder sustained a serious injury during the rescue attempt. The woman then developed PTSD following the event.

“One of her main complaints was guilt—guilt that she didn’t do enough to save these two people,” says Chopko, a former police officer and a current volunteer deputy sheriff. He asked the client to rate her guilt on a scale of 1 to 100, with 100 being the worst. “One hundred,” she responded.

Chopko used a variety of techniques, including prolonged exposure therapy, to help the first responder think differently about what had happened. What turned the tide for the client was an empty chair technique in which they addressed how the victims would feel about her rescue efforts and what they might say to her. “That was a breakthrough moment,” Chopko says. “She told me in the next session that that moment in therapy changed her life. It felt like 1,000 pounds off her shoulders.”

People respond differently to trauma, Chopko says, so the crucial role of the counselor is to discover how a particular trauma has affected a particular client. People can go through the same event...
and have two totally different experiences, he says. After identifying the guilt from which his client was suffering, Chopko and the first responder were able to find success in treatment. After their work together, the client reported her guilt had dropped from 100 to a 2 or a 3.

While trauma affects people in different ways, Chopko says first responders undoubtedly deal with more than their fair share of it. Chopko, who teaches courses and does research on mental health issues in the criminal justice system, particularly post-traumatic stress experienced by first responders and victims of crime, recently conducted a study of 186 police officers throughout Ohio. He found that 17 percent of the officers were displaying probable PTSD symptoms. An additional 10 percent, while not meeting the criteria for PTSD, were displaying post-traumatic symptoms that were still considered significantly distressing. “More than a quarter of all police officers were currently experiencing significant or severe post-traumatic distress,” Chopko says. “Lifetime prevalence rates are much higher.”

“First responders commonly experience traumas as a routine part of their job,” Chopko says, including witnessing scenes of threatened or actual deaths or injuries from accidents, crimes, disasters, fires, suicides and hostage situations, to name a few. “In addition to viewing dead bodies and terrible injuries, first responders often have to put their hands on and handle the mangled and dead bodies,” he continues. “First responders are also often themselves put in life-threatening situations, such as the firefighters who run into a burning house to save others at great risk to themselves or the police officer who has a gun pointed at him, is involved in a shooting or is involved in a high-speed chase.”

Traumatized individuals are having a normal response to a very abnormal situation, Chopko explains. People who experience a traumatic event are expected to display post-traumatic symptoms and distress, he says. The variable is how long the symptoms and distress will last. For some, it is only a few days; for others, it may be a lifetime. First responders and others who have experienced trauma can get stuck in the fight-or-flight response, Chopko says. “This response
helps you immediately survive the life-threatening event. Because the event is so overwhelming, however, the mind and body get stuck in that response. This is why people experience the hyperarousal symptoms — the mind is always waiting for that next terrible event to occur. The memories of the event never get sent into the long-term storage of memory.”

Chopko uses the analogy of a frozen computer. “If you type too many commands into a computer at once, what happens? The computer will freeze up and get stuck. The trauma is so overwhelming, the mind can’t process the horror of what occurred.”

Although survivors of trauma might not want to relive the experience and may avoid talking about it, that strategy won’t work over the long haul, according to Chopko. “People avoid thinking about the event because it produces more symptoms. In the short term, this strategy works by not inducing more severe symptoms. The problem is, this just reinforces your need to keep avoiding the memory to reduce symptoms, and this does not give the brain a chance to process the memory and put it into long-term storage. In the long term, avoidance has the paradoxical effect of making the symptoms worse.”

One of the biggest hurdles to helping first responders heal is the stigma attached to asking for assistance within the first responder community. “The work environment of first responders is one of a macho nature, where signs of weakness are undesirable,” Chopko says. “Many first responders feel highly uncomfortable seeking help because they don’t want to be viewed as weak by their peers and superiors and therefore suffer in silence.”

The best way to address this barrier, he says, is to remind first responders of how normal their feelings are. “This is where normalizing is so important to convey that, ‘No, you are not weak or crazy. In fact, many of the other first responders are also experiencing similar reactions. They are just not talking about it.”

The good news, Chopko says, is that empirically validated treatments such as prolonged exposure therapy work well at reducing negative post-traumatic symptoms. “This type of therapy is sort of like going back and entering the commands into the computer one at a time so the computer can run smoothly without freezing.” In therapy, the client tells the story over and over again until the symptoms are reduced, resulting in the memory being processed and getting placed into long-term storage, he explains. “In this way, the opposite of avoidance is the key to recovery.”

One intervention developed specifically to help first responders is Critical Incident Stress Debriefing (CISD). With this model, all first responders involved in the traumatic event are brought together afterward to debrief. Although research has not been consistent in showing that CISD is successful in preventing future symptoms, Chopko says it offers counselors a chance to get their foot in the door with first responders. Mental health facilitators can lead the debriefings, emphasize to first responders that what they are feeling is normal and then offer them resources for additional help, he says.

Another way for counselors to reach this population is to get involved in programs that train first responders in

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military personnel, which can have a detrimental effect. “The mainstream press has made a huge issue of the mental health concerns of returning warriors,” says Fenell, who served as chair of ACA’s Special Committee on Military and Veterans Affairs. “The military has responded and, in some ways, (that led) to the diagnosis of choice being PTSD, with traumatic brain injury a close second.” Treatment through the Department of Veterans Affairs becomes easier to obtain when the PTSD diagnosis is given, he says, but the diagnosis isn’t always a good thing. “When people are treated as if they are dysfunctional, they become dysfunctional. When people are treated as normal people in the process of getting better, they are more likely to get better.”

That said, Fenell emphasizes that he does not disregard the diagnosis of PTSD. “PTSD is real and can be devastating to those who experience it and those who are close to them,” he says. “If my positive strength-based approach is not effective, I can move to more traditional approaches or refer.”

Fenell says the sooner trauma therapy can begin, the better — as long as the client is able to begin reprocessing the events and the feelings associated with them. “Again, I reassure the client that he or she is experiencing normal reactions to abnormal circumstance and that we will get through this confusing time together. It is a health-based, rather than pathology-based, way of working with the client.”

Fenell offers a few tips for working with members of the military affected by trauma:

- Establish a relationship based on trust. “My military background is invaluable in this regard with combat veterans and their families,” Fenell says.
- Normalize the symptoms.
- Engender hope. “This is crucial,” he says. “Too many civilian therapists communicate pessimism to clients nonverbally when dealing with combat trauma.”
- Ensure that the client accepts and begins to believe that he or she will improve with time and supportive therapy.
- Engage the family in treatment. “The family often begins acting differently around the traumatized client, and this typically makes the client feel worse rather than better,” Fenell says. “Get the family on board and in treatment with the client so that all are emphasizing a strength-based, ‘this will get better’ mind-set.” It’s also helpful to collaborate with the client’s military unit so that it will be positively involved as well, he says.

The greatest challenge for counselors, Fenell says, is being comfortable with the client’s tragic experiences while still expressing empathy and engendering hope. Counselors should be psychologically healthy and well grounded and able to enter the world of the client without being overwhelmed by it, he says. “Psychological health, personal resiliency and lots of experience help.”

But, he cautions counselors, don’t become immune to your own feelings.

“The counselor must be able to express accurate empathy without becoming so overinvolved that therapeutic perspective is lost. Losing perspective and feeling too much, or becoming detached and not feeling at all, can happen to some therapists when dealing with the pain associated with trauma cases over a long period of time.”

A less safe place

One of the things that makes a traumatic event such as the school shootings at Columbine or Virginia Tech so hard to handle is that violence has invaded a safe place, Webber says. “Schools are safe places, homes away from home, full of fun, football pep rallies and friends. It is unimaginable that kids and teachers could be killed in their school. More unbelievable and terrifying is that at Columbine and other schools, they were killed by students.”

In the microcosm of a K-12 school community, traumatic events can take different paths based on who is affected and how many students are affected, says J. Barry Mascari, assistant professor and chair of the Counselor Education Department at Kean University in New Jersey. “Too often, schools treat everyone as if they are impacted to the same degree and inadvertently bring more students into the complex mix than is necessary,” he says.

“Many students may not know the victim and would not have any impact but feel guilty or think they should be more upset. This needs to be normalized,” Mascari says. “The small minority that is impacted also needs
some triaging, because some simply need psychological first aid to help them normalize what they are thinking and feeling. Others may need more direct follow-up because of the closeness to the event or previous trauma. School counselors are in a unique and critical position to help students weather these events and are especially critical in helping administrators manage these crises.

Recently, federal and state governments have begun mandating response plans, and school counselors should play an important role in developing those plans, Mascari says. “When I directed the plans for a large city school district, we did everything from sharing building plans to meeting with the counselors so they understood their role in the response plan. Our school counselors played a critical role in initiating a response.”

Webber says returning to routine — reopening school and restarting classes — as soon as possible is important. Sharing should be encouraged in classes rather than large assemblies, she adds, because counselors and teachers can more readily identify those who might need additional support in smaller settings.

At a university, where there is less structure and containment, it is more difficult to provide immediate support and contact from teachers and counselors, Webber says. Drop-in centers in dorm lounges, dining rooms and other areas can help to decentralize response efforts.

At schools and universities alike, Webber reminds counselors their role is also one of prevention. “National Suicide Awareness Week is one example,” she says. “After students complete brief surveys, counselors follow up with students whose survey results suggest that they may be at risk.”

After disasters strike

From the recent earthquakes in Haiti and Chile to the 2004 Indian Ocean tsunami to the domestic devastation of Hurricane Katrina, natural disasters can strike quickly, but their impact is often enduring, altering the lives of large groups of people. While those who have lost homes and loved ones are most affected, those trying to help can be greatly impacted as well.

The most significant challenge for disaster responders is secondary traumatic stress, says Cirecie West-Olatunji, an associate professor of counselor education and coordinator of the mental health track at the University of Florida. Responders may begin to experience symptoms similar to those exhibited by the disaster survivors, she notes. “This is why self-care is an important part of disaster training,” says West-Olatunji, an ACA member who participated in a recent ACA podcast on the earthquake in Haiti. “Disaster mental health counselors who do not know their limitations and do not have a plan for resilience during service provision can become liabilities during deployment.”

The second most significant challenge is cultural competence, says West-Olatunji, who represents the Association for Multicultural Counseling and Development on the ACA Governing Council. “Given the rise in disasters globally, counselors are likely to be deployed to geographic areas where the cultural mores differ from their own. Thus, they need to exemplify cultural competence that reflects responsiveness and expediency in service provision.”

In the aftermath of Hurricane Katrina, many mental health professionals were sent to the Gulf Coast to help, but some were asked to return home because of a lack of cultural competence, West-Olatunji says. “When counselors lack cultural competence when responding to disasters, they can sometimes aggravate existing symptoms. Culturally competent mental health disaster counselors are able to identify community strengths and mechanisms for healing. They are also able to incorporate community knowledge into their work and expediently apply that knowledge in their interventions.”

West-Olatunji, who lived in New Orleans for 14 years and raised her children there, recalls an experience in the aftermath of Hurricane Katrina in which her knowledge of the people and community became a lifeline. She was working with first responders from the area and their families, who were living temporarily in intact communities aboard cruise ships off the coast of New Orleans. While she was there, people were beginning to move off the ships and into trailers, but many were very resistant to the idea.

Tasked with providing communitywide intervention, West-Olatunji knew from past experience that the people of New Orleans were social. She wanted to get them more comfortable with the idea of moving into the trailers, so instead of sitting inside one of the models and waiting for people to come in and ask questions, she took a chair and sat outside. She spoke to people passing by as if she were sitting on her front porch, and then she’d invite them in. As they sat inside the trailer with her, West-Olatunji remembers, they could see it wasn’t so bad. “That’s an example of using knowledge of the community … as a vehicle to get them where I want them to be,” she says.

Cultural competence is also important in working through the aftermath of a disaster with clients one-on-one, she says. “It is important for counselors to honor the ways in which individuals are coping with their trauma and to acknowledge ways in which they define healing. Counselors often want to bring their own concepts of healing to trauma-affected communities, leaving out the idea that counselors can effectively co-construct solutions with their clients.”

Cultural sensitivity is especially important when it comes to religious beliefs, Zalaquett adds. “Clients’ religious interpretations of their ordeals may conflict with the counselor’s interpretation of the situation,” he says. “Nonetheless, we should not challenge clients’ deep religious beliefs. Helping victims process feelings of guilt and responsibility is one way in which we could serve them better.”

“Clients’ religious interpretations of their ordeals may conflict with the counselor’s interpretation of the situation. Nonetheless, we should not challenge clients’ deep religious beliefs.”
Following the American Red Cross disaster mental health model means the bulk of mental health services are provided only after first responders have addressed more immediate needs, West-Olatunji says. At that point, counselors should look to the most resilient community members. “Counselors can assist by working with the less vulnerable individuals first to help stabilize the community and utilize the most resilient individuals in restoring normalcy to the community,” she says. “Further, disaster mental health counselors can serve as consultants to civil employees, educators and religious and community leaders in providing information on mental health recovery. Oftentimes, individuals will seek assistance from leaders in their own communities before approaching mental health professionals.”

Disaster counseling is very brief in nature, West-Olatunji says, with most sessions conducted in field-based settings. “Any individuals who require more conventional services are referred to existing services in the community,” she says. Another way for counselors to help in the aftermath of a disaster is by providing services to first responders, who are particularly vulnerable to secondary traumatic stress. Counselors from farther away can pitch in by providing assistance to counselors in the affected area, West-Olatunji says. “The most valuable support can be in the form of outreach trips with advanced counseling students, practitioners and counselor educators to provide relief, consultation and training to the affected community of counselors.”

When one works with adults affected by a disaster, West-Olatunji says restoring regularity in their daily activities is important. “This intervention aids in the recovery process in that it reestablishes some predictability to their lives. An example would be attempting to eat meals at prescribed intervals on a daily basis or going to bed at the same time each evening. Ritualizing the daily routine is helpful in restoring a sense of safety and grounding individuals in reality.” She adds that encouraging clients to engage in reflective or meditative activities can also be helpful, as can participating in communitywide or family rituals to aid the grieving process.

When it comes to children, West-Olatunji says it’s important to allow them to tell their stories about the disaster. “Some common interventions with children involve the creative arts,” she says. “Asking children to draw their stories can be a powerful tool that allows them to have a voice and also serves as a platform for therapeutic activity. Other pediatric counseling techniques include working with sand trays, dramatic play, Popsicle stick doll construction, the use of proverbs and mutual storytelling.”

While disasters bring death, destruction and heartache, West-Olatunji says the greatest lesson she has learned about trauma is an optimistic one. “People are much more resilient and psychologically hearty than I imagined. They have taught me a lot about the capacity of the human spirit.”

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Letters to the editor: ct@counseling.org
Fans of TV sitcoms may fondly recall Cheers as the friendly neighborhood bar in Boston “where everybody knows your name.” The regular denizens of Cheers descended the stairs to be enveloped by an unwavering sense of camaraderie. Of equal appeal to these characters, however, was the fact that the bar served as a refuge from the outside world. In truth, outside of a close network of other regulars, relatively few patrons of Cheers “knew their names.” The bar offered a certain sense of anonymity — a place where most other people wouldn’t possess any knowledge of their personal histories, their past mistakes, their baggage, their quirks. Even psychiatrist Frasier Crane frequented Cheers to escape his problems and, in some instances, his clients.

Contrast that with the environment encountered by counselors who work in rural areas, where the phrase “everybody knows your name” is oftentimes a truism, not just a homely slogan. This life-in-a fishbowl aspect of rural counseling offers unique challenges that encompass ethical decision making, boundary issues and counselor self-care.

For instance, says Lauren Paulson, a licensed professional counselor and American Counseling Association member who has conducted research on the topic, counselors in rural areas face greater pressure than their suburban or urban counterparts to serve as role models for clients, even when the counselor is not working. While Frasier Crane could step into Cheers without giving it a second thought, Paulson says drug and alcohol counselors who work in rural areas might question the advisability of having a glass of wine at a local restaurant. “A lot of the (rural) counselors I have talked to said they felt they needed to go out of town before they could truly let down,” says Paulson, a visiting assistant professor at Allegheny College and an adjunct professor at Edinboro University, both in Pennsylvania.

“You’re kind of on display when you’re a counselor in a rural area,” says Dorothy Breen, an ACA member who moved from a metropolitan area just outside of New York City 23 years ago to take a job at the University of Maine. In addition to being an associate professor at the university, Breen maintains a home and a private counseling practice in the western part of the state, which is much more rural in nature than the comparatively cosmopolitan university town of Orono (population 9,114 at the 2000 census).

“The rural setting really influences my work and my life in a lot of ways,” says Breen, who is conducting research on rural counseling during her sabbatical from the university. “I constantly have to be aware of the ethics and boundary issues at play — at the gym, at the bank, in church, at school, in the grocery store. It’s easy to find myself ... right next to one of my clients (in the course of doing everyday activities).”

Culture shock

Though the concept of multicultural competency has steadily taken on more import for counselors, both Breen and Paulson say there is a general lack of information about rural culture and rural counseling in the professional literature and in graduate counseling programs.

“Knowing your culture. That’s
something that gets stressed to all counselors, but not all counselors understand that there is a distinct rural culture,” Paulson says. “At the same time, it’s diverse. Each rural culture is unique. Most counselors have been trained from urban models, and these counselors can experience culture shock as they try to make their way in the rural community without knowing how to ‘speak the language.’”

“It’s not just a matter of providing counseling in rural areas,” Breen advises. “It’s a matter of providing rural counseling. Rural counselors often need different treatment suggestions and face different considerations (than their colleagues in urban and suburban environments).” For example, she says, in an urban area, a counselor might encourage a depressed client to get out of the house and visit an art museum. “But that’s not always available in a rural area. Instead, it might mean going to a school basketball game — the very central part of social life in some rural communities — or doing something active, such as getting out in the woods.”

It is essential that counselors practicing in rural areas understand and respect their clients’ cultural values and beliefs, many of which revolve around family, Breen says. For instance, Breen provides counseling services in a rural school because the area where she lives doesn’t have school counselors. In encouraging students to pursue their education past high school, she has learned the importance of involving families in these discussions. In many cases, these students will be the first in their families to attend college. Sometimes, Breen says, the parents are worried about who will take care of them if their sons or daughters leave the rural community and decide not to return. Other times, students voice concerns that they will not be accepted back fully into the culture even if they want to return after college.

Another difference in rural counseling is the strength of the connection between the counselor and the community, says Breen, who adds that this is simultaneously one of the most positive and most challenging aspects of being a rural counselor. “You really do get to know people, and they depend on you,” she says. “You’re not just the counselor there; you get involved in the community. If you weren’t involved, you wouldn’t be able to be the counselor because they wouldn’t trust you. You’re seen as the person in the community to go to for all kinds of things, and that’s a different kind of lifestyle. You need to be able to balance being available to people with maintaining boundaries and having personal time.”

“Knowing that’s the way it is — being on stage all the time — is important before making the decision to practice in a rural area,” she continues. “It comes as a shock to many urban counselors.”

Ethical uncertainties and other challenges

Working as a counselor in a rural area, “You have to be a generalist,” Breen says. “You have to be prepared for everything.” But that reality can also leave rural counselors questioning whether they might be working outside their scope of practice. “The difficult part when considering counselor ethics is that some people in rural areas won’t get the help they need because a specialist isn’t available,” Breen says. “So the question

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becomes, do you, as a counselor, try to help them instead to the best of your ability?”

Paulson says rural counselors oftentimes must use creative problem solving to make up for a lack of resources, including in the areas of support and supervision. She encourages these counselors to be deliberate in “setting up sidewalks.”

“That means using one of the strengths of their tight-knit rural communities and forming collaborative networks,” she says. “It’s crucial in a rural area to form relationships with the local general practitioner, other mental health professionals, school counselors and other disciplines.” She also recommends that rural counselors make use of peer networking and supervision and take advantage of opportunities to connect with other colleagues at conferences, through professional associations and through online directories. She would like to see the profession develop a central network to allow rural counselors to connect so they could provide support and guidance to one another.

In Breen’s case, there are no doctors or similar professionals in her town. Instead, she collaborates most closely with a local pastor in discussing certain clients. Breen emphasizes that she always obtains signed permission from clients before working with the pastor, but because they generally view Breen and the pastor as primary caretakers of the rural community, clients normally welcome the collaboration. “We’re all there is here, and we try to help people get their needs met the best we can,” Breen says.

Paulson says that’s one lesson some counselors in urban and suburban areas could most benefit from learning from their colleagues in rural areas — making the most of all the resources immediately available to them and building connections with other professionals.

Counseling students and counseling professionals considering the possibility of practicing in a rural area should give serious forethought to how they will navigate the fishbowl aspect of living and working in a small community, especially as it relates to boundaries, privacy, confidentiality and other facets of professional ethics, Breen says. “I’ve handled that by being pleasant but saying very little about myself out in the community. I keep a pretty low profile. Part of it is just having the confidence not to have to talk about myself and being comfortable letting clients see me as I am — for example, in my workout clothes with my hair pulled back — when I’m not in the office.”

If counselors are constantly on display in rural communities, so too are their clients — and their potential clients. “As a counselor, you have a lot of information about members of the community, so you have to think about how to handle that,” Breen says. “In fact, you have a lot of information about your clients before they even start talking to you. As a counselor, you have to be careful, because that information might not be correct, or it might not be the client’s perspective. … I do not talk about myself very much (out in the community). I also do not talk about other people. I think it’s so important to not get into general gossip (as a rural counselor). I truly avoid that because I don’t want to give the impression that I would spread around any information I might have.”

Although counselors are taught to protect client confidentiality, the rural communities in which counselors work might not carry that same expectation, Breen says, and that can be a challenge. “In a rural area, people are very open in some ways. They will very innocently talk about things openly because they assume that everyone else knows already.”

Breen gives an illustration of a typical dilemma that a rural counselor might encounter. While eating at a local restaurant with her family, the counselor is approached by a mother who mentions some problems her child is having. Even though the mother has shared details of the situation in front of the counselor’s family, “My husband and daughter have to accept that I can’t say anything else about it to them,” Breen says. “It’s important for counselors to talk with their family ahead of time so they understand what your job is like and what your professional ethics are. But can you expect your children to keep things confidential when a client or a client’s family or a member of the community has shared details openly in front of them? This is a challenge. While in rural areas, some people may tend to not care about confidentiality, it is important as a professional to do my best to maintain confidentiality.”

Recommendations and considerations

In many cases, Paulson says, rural counselors experience feelings of professional isolation because they do not have easy access to supervision, training, consultation or networking opportunities. Combine that with often heavy caseloads and the daily struggle to navigate boundary issues and maintain some sense of privacy within close-knit communities, and rural counselors can face increased risk for burnout, she says.

That’s why Paulson, who wrote her dissertation on supervisors working in rural areas, continues to conduct research on strategies to help rural counselors compensate. “I love working and living in a rural area, and I wanted to provide ways to support these counselors and enhance the services they provide to their communities,” says Paulson, who is helping to implement a pilot study in her county on providing supervision to mental health workers in rural areas.

Paulson and Breen both acknowledge that rural counselors often have to sacrifice half or even full days of work to...
access supervision and training. Paulson recommends that these counselors use technology to access webinars and online training whenever possible, in addition to pursuing training opportunities at the local, state and national levels. Both counselors would also like to see the profession do more to provide continuing education that focuses specifically on rural aspects of counseling. One educational resource that Paulson recommends is the electronic Journal of Rural Community Psychology (marshall.edu/jrcp).

At the individual level, Breen encourages rural counselors to engage in what she terms “self-study.” In an article on professional counseling in rural settings for the ACA publication VISTAS: Compelling Perspectives on Counseling 2005, Breen and Deborah L. Drew offered questions counselors can use to engage in self-study and better understand their unique experiences. Among the questions:

- In what ways does the rural setting help your counseling practice?
- In what ways does it challenge your practice?
- How does it change your work?
- How does it change your concept of the role of a counselor?
- How does your rural professional role challenge your personal life?
- What can you draw upon from your training that focuses on rural counseling?

Paulson also emphasizes the need for rural counselors to be intentional about practicing self-care. “It’s about making sure you’re balanced in your life and allocating time for yourself,” she says.

Among her suggestions for counselors on the personal development front:

- Develop a personal wellness plan
- Spend time with friends and family
- Travel
- Exercise and watch your nutrition
- Develop your spiritual life

Although rural counselors can face unique challenges, Paulson says, it’s important for them to focus on the many positive aspects of where they work and live, including the slower pace of life, the peace and beauty of their surroundings and the rich, deep relationships they develop within their communities.

Breen, Drew and Mikal Crawford recently surveyed counselor educators to find out if their programs prepare students for rural counseling. They are in the process of analyzing the data and will interview some of the counselor educators as follow-up. Breen believes it...
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would be wise for graduate programs to offer a course on rural counseling. “Even if graduate students are not planning to work there, they might have a client from a rural area, and it’s important to understand the culture,” she says. But to truly understand it, she adds, students and counselor educators also need to experience it. “It’s about encouraging them to get out in the rural communities and observe, to go to the ballgame, to go to town meetings, to do an internship in a rural area. Simply acknowledging that rural counseling is different is a start. But we need to train students to take care of themselves and advocate for themselves and teach them what it might mean to live the rural lifestyle. And we need to train students in ethical decision making so they are better prepared to handle some of the issues they will face in rural areas.”

Speaking of teaching, rural counselors might have a few lessons they could pass on to their colleagues practicing in more populated areas, Breen says. “Other counselors could benefit from rural counselors’ understanding of their community — learning not just what is told to them in session but what life is really like for their clients and neighbors.”

Lauren Paulson is presenting an Education Session on “Preventing Burnout: Supervision and Support Strategies for Rural Counselors and Supervisors” at the ACA Conference in Pittsburgh on March 21 from 7:30-8:30 a.m. in Room 321 of the David L. Lawrence Convention Center.

Jonathan Rollins is editor-in-chief of Counseling Today. Contact him at jrollins@counseling.org.
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Inviting families into the support circle

Much attention is justifiably focused on providing treatment to those diagnosed with a mental illness, but clients’ families are often left to cope on their own as best they can

By Stacy Notaras Murphy

It was 25 years ago when Bette Stewart’s husband was diagnosed with a mental illness. “I felt angry and alone, like my life was coming apart at the seams,” she recalls. “I asked the psychiatrist for help. I know now that if (my husband) was an alcoholic, I would have been referred to Al-Anon (an organization that offers help and support to family members of problem drinkers). But the doctor knew of no place to send me.” Fortunately, Stewart found her way to a support network run by the National Alliance on Mental Illness (NAMI), an organization that serves individuals and families impacted by mental illness via education programs and political advocacy. Today, she coordinates NAMI support groups throughout Maryland.

“These families (who have a loved one with a mental illness) are dealing with trauma. We’ve lost a person whom we cared so much about. That person is very different now. It’s like losing a part of yourself,” Stewart explains. “We don’t let people grieve that publicly. Families often have bad experiences with therapists who don’t take the time to hear all sides of the story.”

Families face substantial adjustments when a loved one is diagnosed with a mental disorder, be it getting accustomed to the side effects of medication or the lifestyle changes needed to maintain emotional stability. Yet many family members find themselves cut out of treatment plans, particularly if the diagnosed individual is an adult. As a result, the families of those who are mentally ill may feel isolated and alone as they struggle to make sense of the changes. In such situations, therapy or support groups may be beneficial, but many in the counseling profession are unaware of how to reach beyond their clients to those family members in need.

“I think it’s a training issue with clinicians. They aren’t trained to work with families of adults (who have been diagnosed with a mental illness),” Stewart says. “They’ll think, ‘My client doesn’t give me permission to speak to his family.’ But if clinicians are trained with the belief that families are beneficial to the (mental health care) consumer, part of the counseling goals can be connected to the family. Once the provider is out of the picture, that family is still there.”

Joyce Burland experienced this challenge in her own life. Her sister was diagnosed with schizophrenia in the 1960s, and her daughter was diagnosed with the same condition in 1980. “We were given no professional advice in 1960, and nothing had changed in 1980. I thought, ‘This can’t go on.’” So Burland, a psychologist, joined NAMI and wrote the curriculum for a course that would help family members find information and support. NAMI now offers the free peer-education program, Family-to-Family, in all 50 states. Burland currently serves as director of NAMI Education Training and Peer Support programs.

“I was convinced that family members who had lived the experience could be very good teachers,” Burland says from her Santa Fe, N.M., home. “We estimate that 225,000 people have taken the 12-week, free course to learn about what is happening to the person they love — what kind of illness they have, what the lived experience is and how to be an effective and active advocate for their family member in treatment. These are things you do automatically if you get diabetes, but it’s not automatic in the mental health field.”
An educational endeavor

NAMI’s Family-to-Family program takes a largely educational approach to supporting family members. The groups, led by former participants who have been trained as presenters, feature information sharing on a variety of topics, including diagnosis, medications, current research, community resources and mental health care advocacy. Group members also hear about the lived experience of those with mental illness and are prepared to face the possibility of crises and relapse scenarios. The program also covers self-care awareness and coping strategies for the group members themselves.

“The incidence of mental illness is very traumatic for the family,” Burland says. “You could see someone who is healthy in May be psychotic by December. We try to help families see that this is as traumatic as a flood or an earthquake.”

Opening themselves to therapy or a support group may not be easy for family members. Some have soured on the thought of therapy or counseling after trying to secure care for their loved ones. Describing the support group community as a “secret society,” Burland explains that it may take years for certain individuals to willingly go to a meeting where they might be identified as having a family member with a mental illness.

Stewart works as a training specialist at the University of Maryland School of Medicine’s Evidence-Based Practice Center in Baltimore. She has been involved in a study measuring the efficacy of the Family-to-Family program that reflects the lack of awareness in the provider community. Her hope is that more clinicians will consider how helpful an informed family can be to a loved one’s overall progress.

“By involving families in treatment, everyone benefits. The more families understand what’s going on, the easier it is to respond in a more appropriate, compassionate and understanding way,” Stewart says. “Sometimes families feel extremely isolated, and it’s beneficial to know that other families experience the same situations. Together, families can learn skills to work more effectively with their family member.”

She mentions the example of one Family-to-Family participant, a man in his 80s who had been locking horns with his mentally ill son for more than 20 years. When the son turned up every holiday in dirty clothes or with body odor, a fight would inevitably result. But the course provided the father with some insight into the challenges of personal hygiene for someone with his son’s diagnosis.

“During a class he sobbed, ‘Why didn’t someone tell me this before? We could have avoided so many miserable times.’ Later, he described the first happy holiday dinner in years because he understood that the best his son could do was to be there on time. They could deal with the fact that he had dirty clothes, whereas before, (the father) would just get angry. People are never too old to learn something that will benefit them,” Stewart says.

The counselor connection

When NAMI was established 31 years ago, its original purpose was to make up for the lack of support and information...
offered to families by the medical community. As such, some NAMI members carried a reasonable amount of guardedness concerning providers, who for years had created a perception that clients’ mental illnesses were generally connected to poor parenting and childhood abuse.

It’s no surprise that when family members felt marginalized and blamed for their loved ones’ struggles, they were wary of interacting with the professional community. But with a better understanding of the biological factors involved in mental illness, some mental health advocates suggest that today’s providers can do much to repair the divisiveness of the past by taking on family support initiatives. Among the benefits to counselors are introducing their traditional services to a new audience and deepening their understanding of the impact of mental illness on the family.

Betsey Neely began looking for mental health resources when the youngest of her three adopted children was showing signs of conduct disorder in school. An Atlanta attorney and single mother at the time, Neely found a local NAMI chapter and took part in Burland’s Family-to-Family course.

“It was the most helpful thing I found anywhere for dealing with a child with mental illness problems,” Neely says. “After that, I was trained to teach Family-to-Family. I taught that for several cycles and really saw how much the family members appreciated and needed the support. When I finally retired from being a lawyer, I decided to go to graduate school for professional counseling.”

While pursuing her degree, Neely, an American Counseling Association member, devised a support group for her practicum at a community mental health center. “I saw there was no help for the families, and I got reenergized,” says Neely, who currently runs a consulting practice that helps clinicians learn how to be better witnesses in legal proceedings.

“I think the time is right now to bring providers into this education movement. There are educators and providers who would be willing to cooperate with NAMI as a family advocacy group, to bring the best of both worlds together,” says Neely,
As therapists, we have the basic therapeutic training in empathy and listening skills — being able to distill what’s being said, getting to the core of it and feeding that back.”

who adds that the waiting lists to join some advocacy-related support groups can be long. “We just don’t have enough volunteers to offer as many (support groups) as are needed, and clinicians can be trained by NAMI and other groups to really understand members’ needs.” Specifically, NAMI’s Provider Education course and a similar program offered by the Depression and Bipolar Support Alliance (DBSA) both feature the perspective of the “mental health consumer” and teach non-blaming ways of reaching out to families and clients.

“I would not say that providers can always do a better job (of leading support groups), because unless you can make the experience useful and relevant to the family that’s suffering, all the education in the world gets you nowhere,” Neely says. “But I do think providers could do an excellent job assuaging the guilt feelings and helping families keep balance in their own lives.” She adds that trained counselors can understand group processing in ways that peer educators may not, thus allowing counselors to help move the sessions toward more productive outcomes.

Likewise, Jessica Swope, a psychology associate with Psych Ed Coaches in Alexandria, Va., believes her professional training lends itself to attending to subtle group dynamics. She currently facilitates a free monthly support group for parents of children diagnosed with attention-deficit/hyperactivity disorder through CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder).

“As therapists, we have the basic therapeutic training in empathy and listening skills — being able to distill what’s being said, getting to the core of it and feeding that back. Having someone skilled in that way in the room can help move the conversation forward so there can be room for more emotional processing,” Swope says. “I am trained to be attentive to all members’ needs, to be tuned into what’s happening with the group members who are talking, as well as those who are not talking. You are able to take the temperature of the group as a whole and steer the conversation in response to that.”

“A trained therapist who doesn’t have the experience of a family member with that particular issue can be useful because that one person is in the room not thinking about things through the lens of their own experience. Therapists are able to provide a sounding board where people can really be heard,” she notes.

Swope also appreciates the value of camaraderie within the group. “That’s the nice thing about having parents dealing with these issues at all stages. The leaders listen for misinformation, and we might tweak or make additional suggestions, but there’s a lot of learning and information sharing taking place.”

Neely emphasizes the importance of showing families they are not alone in their struggles. “Parenting was the hardest thing I’ve ever done — much more difficult than any employment I’ve ever had as an attorney. There is so much personal trauma that comes from that and guilt that gets in the way. I was a single mother with three kids acting out all the time, and I think there are just a lot of people in that dilemma.”

Empathy, not revenue

This type of group work is probably not the space for counselors to make financial gains; these families are often struggling to make ends meet already as they fund their loved ones’ care. Swope says providing pro bono support services fulfills her ethical requirement to be of service to the community.

Highlighting the distinction between support groups such as the one she runs and therapy groups, which have more psychological aims, she notes, “These are people who are spending a lot already on finding the right type of care for their loved ones. It’s important for people to have a place to go where they can get resources (and) support, have their batteries recharged (and) where they don’t feel like it’s a drain in any way.”

Stewart echoes this thought. “Many families don’t have money to put toward treatment and therapy. Sometimes they just need a basic understanding of what’s going on, what happened to my son or daughter. In this difficult financial time, I hope more providers will think of referring people out to what’s available in their own communities. But if providers are interested in learning ways to really work professionally with families, rather than traditional ‘family therapy,’ I hope they will consider learning about family psychoeducation approaches.”

Indeed, psychoeducation can be the key to reaching this population. Counselors may find members of support groups are more interested in learning about their loved ones’ illnesses and how they can help, while less interested — at least initially — in processing the emotional toll of the diagnosis on the family.

At the same time, firsthand knowledge of how mental illnesses impact families can deepen both a counselor’s empathy and case conceptualization skills. Provider education programs are offered through a variety of organizations, including NAMI, DBSA and the Substance Abuse and Mental Health Services Administration.

Swope has also found that spending time listening to support group members describing their experiences has enriched her individual work with AD/HD children and adults. “I’m fairly new to working with this population, and my experience has largely been through my clients. This group work is a good way to fill out the picture for me as a clinician,” she says. “I think (support group work) would be useful for anyone looking to develop a niche practice. It’s a service but also a way of deepening your knowledge as a practitioner. It’s very useful for me to learn from the parents.”

Stacy Notaras Murphy is a licensed professional counselor practicing in Washington, D.C. Contact her at snmurphy@verizon.net.

Letters to the editor:
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Lessons for counselors, circa 500 B.C.E.

Once upon a time (let’s say 2,500 years ago), in a land far, far away (Greece), a man set out on a journey to get his question answered. He traveled through timeworn villages with little more than the shirt on his back that shielded his rough, leathering skin from the oppressive Aegean sun. He walked for days, never questioning the purpose of his journey. He climbed the craggy cliffs of Mount Parnassus, marveling at the famed Temple of Apollo before him. Upon entering the sacred site, he looked up to see messages etched in stone overhead: *gnōthi seauton* (know thyself) and *meden agan* (nothing in excess), words he had likely heard before, because these ideas were woven into the very fabric of his culture. He proceeded into the temple, in awe of the sights before him. He waited patiently for the god Apollo to speak through the priestess and deliver an answer to his question. When the time was right, the Oracle spoke, and the man returned to follow through with the advice he had been given.

As you probably have surmised, this passage describes the quintessential act of advice giving in human history: the Oracle of Delphi. For the ancient Greeks, the Oracle was the wise voice for those who needed an answer to that most important of questions: What should I do? She was in some ways an ancient counselor, the ultimate destination for those needing guidance in a time of challenge, crossroads or crisis. Although I’m guessing most modern counselors do not have *gnōthi seauton* or *meden agan* etched into their office walls (we’re not big on etching these days), we do tend to promote self-awareness and balance, both for ourselves and for our clients. There are obvious differences, however, between we counselors and the Oracle: 1) we are not possessed by a god when we meet with clients; 2) we don’t come to the office wearing our drapery; 3) our clients don’t travel hundreds of miles by foot or horseback to meet with us; 4) we do not need to be high on fumes emanating from fissures in the Earth’s crust to be helpful; and, perhaps most important, 5) we do not tell our clients what to do.

Just as the role of the modern counselor differs significantly from that of the Oracle of Delphi, so too has the traveler changed. The experience of life as a journey or quest is archetypal; everyone travels the journey of life, yet the ways in which we navigate our paths are as varied and unique as we are. Personally speaking, my journey thus far has included more than enough pitfalls and detours, thank you very much. But as a responsible traveler on the road of life, I routinely stop by the side of the road to take in the sights, refuel or pull out a map or compass, depending on what is needed at the time. For me, this article is about pulling off to the side of the road of my career path to make sense of how my education in the Classics (Greek and Latin) in many ways shapes my identity as a counselor. And what better form of validation for what we do than to remind ourselves that our basic philosophy for helping has roots that run over two millennia deep?

As a traveling guide for my clients, I believe in teaching (and reminding myself of) a few enduring lessons. To me, there is something comforting about connecting with the past, about understanding that some problems, as well as solutions, are timeless. And for those lessons, let us now turn to the Ancients …

**Lesson No. 1: Gnothi seauton (Know thyself).** In 399 B.C.E., the ancient Greek philosopher Socrates was condemned to death by a jury of his peers. Although many citizens considered him a rabble-rouser, great thinkers from Plato onward revered him as the father of philosophical discourse. Today, Socrates is perhaps best known for his deathbed quote, “The unexamined life is not worth living.” That statement may be a bit strong, but the overall message is compelling. If you browse the self-help section of your local bookstore, it seems apparent that Socrates may have been on to something.

Clinical counseling texts typically pay homage to the Greeks by providing the origin of the word *diagnosis* (*gnosis*: knowledge/to know; and *dia*: through and through). As counselors, we understand there is so much more to a person than this label — diagnosis. The ancient Greeks understood that to truly know one’s Self, one had to find ways of engaging and connecting with mind, body and spirit. As counselors, we encourage our clients to explore and connect with all parts of Self — to engage the mind, body and spirit, to contemplate their place in this world, to examine their lives.

**Lesson No. 2: Meden agan (Nothing in excess).** It might seem ironic that an ancient Greek traveled perhaps hundreds of miles through the countryside and up a steep mountainside only to be greeted with the words “nothing in excess.” I don’t know about you, but that doesn’t seem like moderation to me. At this point, it behooves me to mention that our interpretation of this message, as with many modern interpretations of ancient beliefs, should be made with extreme caution. Clearly, our definition of excess would differ considerably from the ancient Greek definition. The spirit behind the message, however, is enduring: Balance is good.

If you come from a cognitive orientation, you likely resonate with this theme as it relates to problematic thinking. In fact, doesn’t the saying go, “Never use *always* and *never*. You will never be right always, and you will always be right never.” As counselors, we work to help people correct their problematic thinking and to adopt shades of gray when making interpretations. Behaviorally speaking, I believe that physical, mental and emotional health often comes with balance. As counselors,
we often try to help our clients achieve balance in life, whether with respect to the roles they play, the activities they engage in, their personality traits and response styles or their mind-body-spirit health. Balance is about achieving equilibrium, and it seems everyone could stand to readjust their fulcrum every now and again. When working with clients who struggle to regulate their emotions, or who feel one emotion in excess of the others, we help them explore their feelings and learn new skills for achieving emotional balance.

Lesson No. 3: Take care when in-between. It should be said that the ancient Greeks were notoriously superstitious and gods-fearing people. It seems they had a ritual, prayer or rule for just about every occasion. Although some may seem quite strange when viewed through our modern lens (for example, don’t clip your toenails on the temple grounds or urinate facing the sun), a few make a great deal of sense even today — especially their beliefs concerning transitions, or being in a liminal state.

Liminality (which derives from Latin means “threshold”) is a term that can apply to a physical, social, psychological, neurological or metaphysical/spiritual state of being in-between. Traditionally, the term liminal was applied to places such as doorways, borders and purgatory; noon, midnight and the change of seasons; creatures such as dolphins, crabs and whales; plants such as seaweed; the time immediately following someone’s death; ghosts; and adolescence. What do these things have in common? You guessed it: They all possess the quality of being in-between. A border is neither here nor there. Fall is neither summer nor winter. A dolphin lives in the sea but must breathe the air.

The Greeks held both simple and elaborate rituals to protect people when they were in a liminal state. They could be especially wary of doorways (you were neither out nor in), funeral processions (no longer alive, not yet buried) and adolescence (no longer a child, but not yet an adult). Why, you may ask, did they believe protection was necessary? Because they believed there was vulnerability in being in-between. To the Ancients, being in-between meant that you were easy prey for evil spirits and the like. This was a time to make special sacrifices to the gods, to pray and to engage in rituals thought to protect one’s spirit from harm.

When you think about it, we have all experienced liminality at some point in our lives. For instance, if you are a counselor reading this, then you survived adolescence (congratulations), which was a time of great vulnerability and uncertainty for many. You have also likely experienced a conflict or issue that did not reach resolution. Some have experienced engagements; others, separations and divorces. The same goes for unemployment and other career transitions. My point is that none of us is a stranger to the in-between. The term might be new to you, but the experience of liminality is universal. What also may be new is the knowledge that for more than 2,500 years, some have been well aware of the potential dangers inherent in being in transition. Being in-between is vulnerable, and being vulnerable creates an opening for the possibility of either good or harm. The ancient Greeks knew this, and they took measures to protect themselves from harmful influence.

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While their “measures” may seem archaic and downright strange to us now, we should still heed their intent.

In writing this article, I feel as though I’ve crafted a terribly important opus for myself and, in doing so, have practiced the three lessons I have excavated from ancient Greece. In fact, when faced with a particularly difficult challenge in life, I typically check in with myself to make sure that I 1) have awareness of my thoughts, feelings and actions (gnothi seauton); 2) am attempting to find balance and avoiding excesses (meden agan); and 3) am caring for myself until I have moved through it. It has been a struggle determining how best to synthesize what was starting to feel like two disconnected Selves — my Counselor Self and my Classicist Self. It feels good to begin to articulate it. It feels good to be both/and.

P.S. (post scriptum: after what was written)

Recently, as a new client walked into my office for the very first time, she asked me a very important question. “I read your online profile,” she mused. “What does a degree in Greek and Latin have to do with counseling?”

As she settled into the couch, flanked by a box of tissues and a marble bust of Athene (goddess of wisdom), I smiled confidently and replied, “More than you’d think.”

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Sandra Gibson published a Reader Viewpoint article about the Gestalt empty chair intervention technique for grief counseling in the September 2009 issue of Counseling Today. Fritz Perls, the founder of Gestalt therapy, and Jacob L. Moreno, the founder of psychodrama, explain the empty chair technique differently. Perls believed the client should imagine an absent person in an empty chair, while Moreno believed the client should reverse roles and become the absent person. Therein lies the fundamental difference between Gestalt therapy and psychodrama and the use of the empty chair technique. This article gives an example of how to establish the presence of the absent person in the empty chair by using role reversal. The following is the story of Paul, recently widowed.

Paul sits mindlessly staring at the television. It has been nine months since his beloved Carmen died. He spends most of his days in that chair except for when he goes shopping, attends church or is with his friends. Funny thing about friends. Right after Carmen died, they called and included him in different activities. Now, after almost a year, they don’t come around very often. Paul knows part of that is his fault. He would rather be alone most of the time. He tells his friends, “I just don’t enjoy things without Carmen.” Paul has never been a person who talks openly about his feelings or problems. Yet Paul has said to very close friends, “I still talk to her. Do you think that is wrong?” His friends tell him they don’t think so but also advise him that it would be a good idea to talk to someone who helps people who have lost a loved one.

I met Paul almost 10 months after his wife had died. We spent our first session trying to determine (as Kenneth Doka writes) how Paul defined attachment.

That is, how he gave meaning to the loss of Carmen. I also wanted to get some idea of how Paul grieved. Did he grieve with an obvious degree of emotion and affect, or did he grieve more cognitively by talking about his lost relationship? As I listened to Paul, it became obvious that he probably dealt with his loss cognitively. He seldom used “feeling” words and usually described activities with Carmen.

Knowing he missed talking things over with Carmen, I decided to use the empty chair technique so he could “talk” with her and thereby find a way to live more comfortably with his grief. Many writers mention using the Gestalt empty chair technique. I prefer to follow the empty chair technique shaped by Moreno from his psychodrama method.

According to Moreno, the empty chair method requires that the absent person be brought to the session by role reversal rather than by asking the client to speak “as if the person is actually in the chair” (as Gibson accurately described the Gestalt empty chair approach). Moreno believed that pretense diluted the power of the process. Therefore, with the psychodrama method, a counselor asks the client to sit in the empty chair and “be” the absent person. As the counselor then “interviews” the absent person, two things occur. First, the counselor gathers valuable information about the absent person. Second, the absent person becomes existentially present. That is, the empty chair is no longer empty; the absent person occupies it, and the client quite easily sees the absent person present in the moment. In my opinion, Moreno’s role reversal approach is more compelling and brings the experience more completely into the moment than the Gestalt approach. Let me demonstrate.

In the second session with Paul, I say, “Paul, put that empty chair across from you. Now move over and sit in the empty chair. I want to meet Carmen, and the best way to do that is to talk to her. I want you to be Carmen. I want you to sit in that chair the way Carmen sits in a chair. I want you to capture the way Carmen answers questions. I want you to be Carmen in every way you can. You know Carmen better than anyone, so I know you can do that.”

Notice that I try to be clear about what I want him to do. Notice also that I do not give him a choice. He is with me to get help, and I need to manage the session so that happens.

Paul sits in the empty chair. I begin with the least threatening questions first. “Carmen, thank you for being here. How old were you when you died?”

Paul (as Carmen) says, “I was 62 and Paul was 64.”

I ask, “How did you die?”

Paul answers (as Carmen), “I died from lung cancer.”

I continue: “What did you love most about Paul?”

Paul (as Carmen) says, “He was good to me. We did almost everything together, and we always made decisions together.”

I respond, “Carmen, Paul is here. He has missed you very, very much. I think he needs to talk to you.”

Let me make a comment about what I have done so far in the session. I have established the “presence” of Carmen. I have discovered that Paul saw himself and Carmen as inseparable. Therefore, his grief is connected to the loss of an active participant in his life. Of course, connected to that is the sadness with which he continues to live. Now, as we progress, Carmen’s presence is no pretense. She is clearly in our session.

I continue the session and say, “Please reverse roles and be Paul.” Paul moves back to his seat and looks at the “empty” chair that now holds Carmen. I say,
“Paul, many thoughts have crossed your mind during the lonely days since Carmen died. She is here. What do you want her to know? Tell her.”

Paul looks intently at the chair and in a quiet voice says, “I have really missed talking things over with you. You always did so many little things like stopping and starting the newspaper when we were gone and buying the kind of food that was healthy for me. I relied on you to do so many of those little things. I tell you, Carmen, I feel really lost without you. But you know what, Carmen? What I probably miss most is just hearing you in the house! It is just so darn quiet, I don’t know what to do.”

The dialogue continues along these lines until I think Paul has come full circle. I then know we need to move toward an encounter with Carmen focused on how Paul is going to move forward. I have found one of the best ways to do this is by creating a “wisdom figure.” In this case, I endow Carmen with the wisdom.

I say, “Paul, Carmen has been gone almost a year, so let’s assume she has been endowed with wisdom beyond what we mortals possess. Think of Carmen as having that gift, and talk to her about where you go from here.”

Paul looks at Carmen and says, “I’m not going to stop mourning and being sad, but I know I can’t continue staring at the TV set. I just am not sure what I should do.”

Paul reverses roles with Carmen, and I say to her, “Carmen, you have been able to watch Paul, and you have wisdom to help him. He has made it clear he is not ready to stop mourning your loss, but he thinks it is time to do more than watch TV. Tell him what to do.”

What I have done in giving Carmen the gift of wisdom is to empower Paul to get beyond himself. Be aware that this may not happen until the third or fourth session. I have truncated this session to give readers an idea of psychodrama role reversal and to illustrate that the power lies within the client.

I leave Paul in the role of Carmen. He says (as Carmen), “Paul, you know you have not been alone. I have been there in spirit. It is time you begin to do some things that get you moving out of the house. Your friends from the plant have asked you to come to their card games, and I know the church is always looking for ushers. You know how to get started doing things. You always did woodworking around the house. I know that Casa De Los Ninos always needs someone to do small jobs for the center. The thing is, Paul, I don’t want you to forget me, but neither do I want you to shrivel up and die.”

I say, “Reverse roles.”

Paul returns to his own chair, and I move the empty chair away. I then ask, “What did you learn?”

He answers, “I learned that I don’t need to stop grieving, but I can start living on my own.”

After we visit a little while about that, I ask, “Paul, do you want to come back to see me?”

Paul says, “Yes. If you don’t mind, I might want to talk to Carmen again.”

I have been struck by the frequency with which Gestalt empty chair is mentioned in publications about grief work in comparison with psychodrama empty chair. Part of that is because Perls was skilled at creating an appealing public image, while Moreno was less publicly known. The other part is that psychodrama has been cloistered behind an extensive set of training standards, and it is essentially a group therapy method steeped in sociometry. I hope this article whets your appetite for the psychodrama process of role reversal and the psychodrama empty chair technique. Check out psychodrama training centers near you.

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Counseling’s role in America’s economic recovery

An ACA interview with career development icon Edwin L. Herr

Editor’s note: Frank Burnett conducted the following interview for publication in the Winter 2010 edition of ACAeNews for Counselor Educators, one of four special focus e-newsletters produced by the American Counseling Association.

As the economy and job market continue to present challenges for many Americans, counselors likewise continue to ask how they might best help their clients face these challenges. Edwin L. Herr, a prolific writer and researcher in the areas of career development, career counseling and work issues, took some time recently to share his perspective on the role counselors can play in helping their clients — and, in the process, our nation — to stabilize.

Herr has served as president of the American Counseling Association, the Association for Counselor Education and Supervision and the National Career Development Association. His accomplishments as a teacher, author, researcher and administrator at the Pennsylvania State University are a model for aspiring counselor educators and academic administrators. Today, he holds the rank of distinguished professor emeritus of education and associate dean emeritus at Penn State, where he also is codirector of the Center for the Study of Career Development and Public Policy.

Considering the current times, how can counseling and counselors contribute to the economic recovery of our nation?

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the reorganization of work; the use of advanced technology in the workplace and in the counseling setting; the importance of lifelong learning; the effects of globalization and the role of international competition on the creation of new jobs and the elimination of many traditional jobs; corporate environments that increasingly use outsourcing, offshoring and the extensive use of part-time workers tied to production cycles; the emphasis on non-human processes of productivity — advanced technology, robots, computer-driven machinery, etc.; and the importance of labor surpluses and skill shortages. Each of these and other dynamics constitute the context that workers must deal with in the future and must understand. Obviously, counselors, too, must understand the language of change and how it affects individual workers.

Counselors also must be alert to the expectations that clients, employers, policy-makers and others have of them. For example, two very old but important terms that both counselors and clients need to understand are frictional unemployment and structural unemployment. Frictional unemployment concerns how long one is unemployed, how that time between jobs could be reduced and what strategies a worker should use — for example, networking — to pursue work. Structural unemployment addresses the reality that a client’s skills and those required by the jobs they are pursuing do not match. In such cases, the skills the client has are not elastic or transportable from job to job. Therefore, the client is either in need of retraining to acquire the skills necessary in the work desired or seeking another career path in which the skills possessed are compatible.

What must counselors know about the American worker and workplace?

One is that in the United States and other nations, career paths have been changed. Many have been eliminated. Others have been created as a function of advanced technology, outsourcing and changes in the organization of work. Many of these new career paths require new skills. The new status quo for workers is characterized as continuous learning and feeling continuously on the edge, off balance. Thus, being prepared to adjust, to adapt, to the frequent transformations in the workplace is an ongoing factor in the lives of workers (as) the global economy is shaping and reshaping the organization of work and how it is done.

But, having said this, the changes in the workplace and the processes by which work is done have affected individual career development in many nations and many organizations. The paths to and through the careers of many workers are no longer linear, predictable, long term and secure. The availability of lifelong employment in one firm, one corporation, one occupation or one job is very unlikely, even though a generation ago, many workers expected such a career pattern. They hoped to obtain employment in an organization, advance through the ranks and retire. The phases of such a pattern — exploration, preparation, induction, consolidation, advancement and retirement — were age-related, understood and anticipated. That view of career development is significantly less likely to occur in a rapidly changing global economy where one’s career development will be shorter, more fragmented, more abrupt, more mobile, more spontaneous, more values-oriented (and) more influenced by environmental and organizational flux, unpredictability and turbulence.

What differences do you see in the needs of clients?

I see several perspectives merging here. One is that counseling about work is likely to require a fusion of career counseling and personal counseling. Many workers coming to counselors will do so out of anger and confusion. While they will likely need to examine the implications of structural or frictional unemployment and its meaning to them, they will also need to consider their emotions about losing their job. Before trying to negotiate new career paths, counselors will need to help them answer questions like, “Why did I lose my job? Why me? What could I have done differently? Why don’t I fit into this workplace anymore?”

This means that in the new workplace, with its frequent transition and change, new sets of skills are often needed. These
are not just technical or job skills. They are called by some authors protean career skills. These skills accent the importance of individuals being able to constantly adapt to change, being personally flexible and taking personal responsibility for their careers. In addition, workers are expected to plan and engage in lifelong learning — anticipate and prepare for trends potentially affecting their career development rather than expecting employers to create and be responsible for the individual worker’s career development.

Another scenario reflects the reality that a worldwide labor surplus, consisting of many well-educated and trained persons for whom there are not adequate opportunities to work in their own nation, raises the level of competition for any given worker. Within the global labor surplus, there is almost an unlimited supply of industrious and educated workers willing to work at a fraction of U.S. wages. These persons naturally gravitate to the economic opportunities available in the U.S., intensifying immigration at a level, even with visa controls, similar to that which occurred 100 years ago at the height of the industrial revolution. They also add to the competition for jobs, heighten the anxiety about who will be employed and raise questions about the fairness of who is hired. Thus, career counseling and personal counseling, together and separately, must be used with clients trying to understand their employment status, their needed skill development and their emotions related to the uncertainty of the opportunities for the work they seek.

A further scenario has to do with the work of the counselor. In an era of professional counselors dealing with a wide range of clients seeking employment and work adjustment, it is important to note that counseling is an umbrella term. Career counseling is almost always embedded in a program of supplementary activities which augments or goes beyond the one-to-one interaction of a counselor and a client. Career counseling may involve a comprehensive program that includes such elements as anger management, support groups, communication skills, job search skills, the use of simulation and gaming, use of computer databases of potential employers and other forms of information, how to manage one’s career development and how to cope with change. Career counseling also may involve use of referrals, job shadowing, information interviews with employers and other sources of recommendations for employment.

Finally, there is the issue of human capital investment. It is important for counselors to know this term and use it with clients when appropriate. At a national or organizational level, human capital may mean the numbers and types of skilled, educated people available to do the work of the nation. At an individual level, it is important for the counselor and the client to consider that each person possesses his or her own human capital and the possibility to invest it.

Thus, at the individual level, human capital can be identified by its elements. For example, ability, behavior, effort and time. Each of these sets of behavior can be managed and used by the client as an investment in their job. Each can be analyzed and discussed with the
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CONTINUING ED CREDIT

Stahn's "Miracle List" technique asks

1. According to Zalaquett, in disaster situations, counselors should begin providing counseling immediately, if possible.
   - True
   - False

2. In Chopko's study, more than ___ of all police officers were currently experiencing significant or severe post-traumatic stress.
   - a. a fifth
   - b. a quarter
   - c. a third
   - d. a half

3. According to Stewart, counselors do not reach beyond their clients to those family members in need because they:
   - a. lack training.
   - b. feel protective of their clients.
   - c. don't recognize the need.
   - d. All of the above

4. All of the following are true about NAMI's Family-to-Family program groups EXCEPT they:
   - a. feature information sharing on a variety of topics.
   - b. are led by former participants.
   - c. help prepare members for crises and relapse scenarios.
   - d. facilitate emotional processing.

5. Stahn's "Miracle List" technique asks clients to rate their miracles by all of the following EXCEPT:
   - a. want
   - b. possibility
   - c. control
   - d. willingness

6. The author has found one of the best ways to help clients figure out how to move forward within the empty chair technique is:
   - a. by creating a "wisdom figure."
   - b. by using psychodrama role reversal.
   - c. by empowering the patient to get beyond him or herself.
   - d. by giving the patient a mirror.

7. According to Breen, ___ is simultaneously one of the most positive and most challenging aspects of being a rural counselor.
   - a. the strength of the connection between the counselor and the community
   - b. being a role model who is constantly on display
   - c. being seen as a go-to person for all kinds of things and having to be a generalist
   - d. using creative problem solving to make up for a lack of resources

8. According to Breen, in rural areas, most people don't care about confidentiality.
   - a. True
   - b. False

9. Counselors are required to retain the paper originals of some documents for legal reasons.
   - a. True
   - b. False

10. Herr's "language of change" includes:
    - a. the reorganization of work.
    - b. ability, behavior, effort and time.
    - c. protein career skills.
    - d. frictional unemployment and structural unemployment.

Think of it: Every issue you could be eligible for one hour of credit through this program which is approved by the National Board for Certified Counselors and now, also, the Florida Board of Mental Health Counseling. That means you may be able to earn up to 12 credits per year and up to 60 credits in 5 years. That's potentially more than half the total requirements you currently need to recertify as an NCC—for a remarkably low price! And NBCC approved home-study credits are often acceptable to State Licensing Boards. Check your local rules.

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counselor in terms of how much each of these behaviors is being used by the client. How much is not being used? What are the obstacles to being the most effective worker possible? What is the expected return on investment? What are they seeking from work — for example, prestige, amount of income, interesting work? Each of these elements of human capital investment can and should be a target of intervention. Clearly, these elements underlie individual motivation and tie together performance, behavior and skill investment, and clarity of client understanding about how to frame one’s commitment to work.

How will counselors and counseling make a difference?

There is no easy answer to how counselors and counseling can contribute to the economic recovery of the nation. Research tells us that each of the techniques mentioned here have been found to be effective. The problem then is one of capacity. There needs to be enough trained, skilled and available counselors to create and deliver programs that address workers who need different kinds of job-seeking assistance, including counseling.

An alternative approach is to do what some one-stop centers and other employment services are doing. Basically, they have set up “triage” processes by which they can classify new clients into those who can work on their own to examine available information, those who can work within support or information groups to learn about job-seeking processes and, third, those who really need one-to-one counseling. In the first two groups, the use of counselor time is minimal and, thus, saved for clients who really need direct interaction with the counselor.

Such an approach saves the time of counselors to work with people who really do not need to be counseled but need other services. This approach adds to capacity time without adding more counselors to the staff. In such creative ways, more counseling can be available and more persons served.

Counselors are committed to helping each person seeking work to find it, to strengthen their job skills and to learn the importance of personal flexibility. Ultimately, in their understanding of change in the workplace and their assistance to displaced workers in applying the skills related to change, each counselor and counseling contributes to the economic recovery of the nation.

Frank Burtnett is the editor of ACAeNews as well as ACA’s four special focus e-newsletters for counselor educators; school counselors; counseling students and new professionals; and mental health, private practice and community agency counselors. Contact him at fburtnett@counseling.org. The four special focus e-newsletters are sent free to ACA members on an “opt-in” basis. To opt in, contact Member Services at 800.347.6647 ext. 222 or send an e-mail to acamemberservices@counseling.org. The regular ACAeNews is published 24 times per year and is sent automatically to all members who have included an e-mail address in their membership file.

Letters to the editor: ct@counseling.org

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Greetings from the State Divisions Committee of the American College Counseling Association. At this time, we are seeking committee members. This is a volunteer position that seeks to help state divisions maintain or reenergize their charters and, subsequently, their membership. Additionally, the committee requests reports from state divisions in an effort to address needs and concerns, as well as to report successes.

Many states have inactive charters or have never had a chartered state division of ACCA. If you or a colleague have an interest in engaging college counselors in your state, contact us for more information. Moreover, if you have a state division but have not been in contact with the committee, please contact us at sborne@dcc.edu for an answer to your state’s status.

Thank you for your interest. We look forward to hearing from you.

C-AHEAD announces grant and award recipients
Submitted by Jeff L. Cochran and Cathy Malchiodi jcochr11@utk.edu cmalchiodi@insightbb.com
The Counseling Association for Humanistic Education and Development is pleased to announce this year’s winner and runner-up applicant in our Make a Difference Grant competition. The grant supports research with a humanistic philosophy by up-and-coming counselor educators that will make a significant and positive difference in the lives of others. The members of our review committee enjoyed the breadth and depth of the research pursued by the applicants.

This year’s grant recipient is Kara Carnes-Holt. Carnes-Holt’s project is “The Efficacy of Child-Parent Relationship Therapy With Adopted Children and Their Parents: Effects on Child Behavior, Parent-Child Relationship Stress and Parental Empathy.” As Carnes-Holt wrote describing her project, “Individuals are created to be in relationship,” and “the parent-child relationship is the initial and essential medium for creating safety and love.” Carnes-Holt points out adoptive parents face additional challenges in the development of their children, making clear the need to establish relationships that create feelings of security, trust and permanency. Carnes-Holt’s work should shed light on the power of child-parent relationship therapy to help with the challenges that adoptive families face.

The runner-up in the competition is Kelly Emelianchik, whose project is “The Initial Development and Validation of the Teen Screen for Dating Violence.” Through her project, Emelianchik is expected to make a significant positive impact on the cycle of dating violence among teen girls and boys. The instrument she is developing will help assess teens’ past and present experiences with dating violence, as well as explore risk factors that are connected to a high likelihood that violence may take place in future dating relationships.

We wish the very best to these researchers and all those who applied. We wish we could assist in funding all the excellent applicants.

In other news, C-AHEAD is pleased to recognize Michelle Perepiczka as the recipient of the 2010 Outstanding Humanistic Dissertation Award. Perepiczka is honored for her humanistic dissertation research investigating wellness of counselor education doctoral students.
Ahmed Mostafa, an NCDA Career Development Facilitator (CDF) instructor from the University of Cairo, is organizing the Egypt Career Development Association. Mostafa received his CDF training this past year through an agreement between NCDA and the International Youth Federation.

Perepiczka was nominated by her doctoral committee chairperson, Richard Balkin of Texas A&M University-Corpus Christi. Perepiczka is being recognized at the C-AHEAD breakfast at the American Counseling Association Conference in Pittsburgh.

**EB-ACA session teaches self-esteem across the life span**

Submitted by Maria Ebert
maria.ebert@eu.dodea.edu

Mary H. Guindon offered members of the European Branch of ACA a truly thought-provoking and energizing Learning Institute on the topic of self-esteem at the 50th Annual Fall Conference in Weiskirchen, Germany, on Nov. 7-8.

Self-esteem was defined, breaking it down into significant components (including both elements of “worth” and “competence”), and specific meanings were given to those components. Guindon targeted cognitive, affective, behavioral and evaluative elements. In addition, differences between global self-esteem (an overall estimate of general self-worth) and selective self-esteem (an evaluation of specific traits or qualities that may be transitory and vary according to life situations) were discussed.

Guindon introduced us to a broad menu of techniques to assist in uncovering the weight or value that we give to the elements that comprise our sense of self-worth.

Our sense of identity is generally grounded in the norms of the particular culture we live in, and self-esteem is learned as we receive opinions and feedback from significant others. Our self-evaluations are also based on how we understand and appreciate our own achievements. Significant developmental events, such as illnesses or retirement, or even nonevents, such as not finding the right partner to marry, may take a toll on, or enhance, the self-esteem of a person.

Some of the tools we explored included values-clarification methods, cognitive restructuring techniques, ways to uncover low self-esteem triggers, reframing negative attributes into more realistic self-evaluations and interventions aimed at increasing the perceptions of one’s own strengths and taking ownership of past accomplishments. We developed structured interventions suitable for a wide range of ages and counseling settings. We left the workshop with numerous valuable additions to our treasure chests of counseling skills.


**NCDA conducts training in Qatar**

Submitted by Deneen Pennington
dpen@ncda.org

The National Career Development Association, in collaboration with the Higher Education Institute (HEI) of Qatar, conducted its Career Development Facilitator Training for 40 Qatari career staff in a two-part series this past year. Howard Splete and Ellen Weaver-Paquette were selected as the NCDA training team to work with this prestigious group.

NCDA has future plans to coordinate university visits for HEI as its colleagues pursue admission into various U.S. universities. NCDA is proud to assist this Middle Eastern country as it expands and enhances career development services to its future labor market.

NCDA has additional planned collaborations with Jordan, Egypt, Oman, South Africa and India. As these countries strengthen their local economies and identify their future labor market needs, career development training is key to their success.
Grad student essay competitions offer new points of view

Four essays chosen as runner-up winners in ACA Foundation contest

A number of reasons exist for holding the annual ACA Foundation Graduate Student Essay Contest and the Ross Trust Graduate Student Essay Competition for Future School Counselors. High on that list is the opportunity these contests provide for counselors new to the profession to share their insights and ideas on subjects of interest to the entire counseling community.

This year’s competitions drew record numbers of entries and diverse responses to the essay subjects offered for the two competitions. Whether offering ideas related to health care reform and counseling services or identifying populations the writers felt were underserved by current counseling practices, it was clear to the experienced counselors evaluating the essays that these counseling graduate students had thought hard about the subjects they were addressing and usually felt strongly about the opinions they were offering.

The four essays presented here are the runner-up winners in the ACA Foundation 2010 Graduate Student Essay Contest. Each of these students has been awarded a $500 scholarship grant and free registration to the ACA Conference & Exposition in Pittsburgh. Next month's issue of Counseling Today will feature the four runner-up essays from the Ross Trust competition. The two grand prize-winning essays were published in the March issue of Counseling Today.

Note: Counseling Today has edited the following essays only for spelling and minor style issues. The views expressed are those of the authors.

Donny L. Baca
Donny L. Baca is a former police officer turned counselor residing in Fountain, Colo. He is doing graduate work at the University of Northern Colorado in Greeley.

Name the population in this country that you feel is most underserved by the counseling profession, and explain what you think could be done to better address this group.

I arrived on scene at 7:09 p.m. The front door of the residence was open. I walked into the bedroom to my immediate right. There I saw one volunteer firefighter kneeling beside a small child, passionately working on stabilizing her condition. The child, a 2-year-old baby girl, was lying on the bed, motionless and helpless; she was nonresponsive. Her head was turned slightly to the right and her eyes were open, staring into my eyes — the stare I have seen one too many times. I could see the dried tears she had shed, softly crusting on the sides of her cheeks. Her chest was moving, slightly, in her exacerbated attempts of taking her faint and final breaths. Today, I can still see her as clearly as the night she lost her life.

Law enforcement officers have encountered countless victims such as the one I have described. Having firsthand knowledge of the lifestyle law enforcement officers must rationally cope with violence, death, destruction, verbal abuse and resentment. The ambiguity of daily exposure to known and unknown threats causes an officer to experience job-related stressors (organizational, operational and situational). It is the stressors that often lead officers to succumb to “alcoholism, barbiturate andamphetamine use, chronic suspiciousness and cynicism, emotional detachment and psychiatric symptomology: rapid mood changes, sleep disturbances, depression, anxiety and over-hostility” (Ostrov, 1986). This is an overwhelming epidemic in the law enforcement career field and increases the potential of suicide. In 2007, 143 sheriff’s deputies and police officers were killed on duty; sorrowfully, over 300 officers take their own life each year (Kirdahy, 2008).

A police officer’s daily work can have negative effects on their personal life; the emotionally unfit cannot meet these stressors. Law enforcement agencies across the United States have followed and enforced this philosophy. This philosophy prevents officers from not only seeking clinical treatment but also prevents them from receiving appropriate resources. There appear to be several barriers that prevent officers from obtaining mental health services: the stigma that the helpers are looked down upon if they are in need of help themselves, law enforcement officers’ mental health and welfare. It wasn’t until I began my graduate studies in clinical counseling, encompassed with my experience as a law enforcement officer, that I recognized the lack of research, training and resources available to mental health professionals who provide services to law enforcement officers and first responders.

Each day as a police officer starts his/her shift, they are uncertain of what events they will be exposed to. Officers must rationally cope with violence, death, destruction, verbal abuse and resentment. The ambiguity of daily exposure to known and unknown threats causes an officer to experience job-related stressors (organizational, operational and situational). It is the stressors that often lead officers to succumb to “alcoholism, barbiturate andamphetamine use, chronic suspiciousness and cynicism, emotional detachment and psychiatric symptomology: rapid mood changes, sleep disturbances, depression, anxiety and over-hostility” (Ostrov, 1986). This is an overwhelming epidemic in the law enforcement career field and increases the potential of suicide. In 2007, 143 sheriff’s deputies and police officers were killed on duty; sorrowfully, over 300 officers take their own life each year (Kirdahy, 2008).

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officers are encompassed within their own subculture and the challenges within officer minority groups (i.e., sexual orientation, gender and race).

It has been my experience that mental health professionals do not understand the depth of issues law enforcement officers are plagued with. It is essential that continuous research focused on law enforcement officers be conducted. Additional research will provide the mental health profession a better understanding of the subculture within law enforcement. It is also imperative that mental health professionals receive training in areas specific to law enforcement officers (i.e., post-traumatic stress disorder, vicarious trauma, marriage and family counseling). The mental health profession has made decades of tremendous strides in increasing knowledge and training. With my experience and continuous goals in education, my personal investment to the mental health field and to my brothers and sisters in law enforcement, I hope to contribute to a population who I feel is most underserved by the counseling profession.

Cyndi B. Dennemann

Cyndi B. Dennemann is a graduate counseling student living in Florence, Ky., and doing graduate work at Xavier University in Cincinnati.

In your opinion, have recent economic changes led to new problems that the counseling community should address? If yes, what actions would you suggest?

It was in the late sixties when Bob Dylan sang, “When you’ve got nothing, you’ve got nothing to lose.” Fifty years later, people all over America live with the daily fear that they are a pink slip away from that scenario.

Workers all over the nation, from blue-collar hourlies to executives, are working longer hours, taking fewer vacations and feeling less secure in their positions despite their sacrifices. Employers are desperate to keep productivity up and costs down, so they continue laying off workers and demanding more of the ones who stay on. Jobs are scarce, poverty rates are up and charitable giving is down. It is not the first time the economy has gone downhill, but the scope of the situation is something new.

Americans have often been characterized by optimism, the notion that one can rise up from poverty and live a life of plenty. The ideas that hard work will reap just rewards and that positive thinking will protect us from suffering — these are just a few of the truisms that are failing us in this troubled time. In my opinion, these recent changes and the societal shortcomings they have brought to light reveal an existential crisis that is affecting the whole culture.

These changes have brought people into counselors’ offices. They are insecure about their ability to provide for their families and pay their bills. Workplace stresses that result from the economic downturn leave people feeling persecuted and underappreciated. Their employment status feels tenuous. Those who have been laid off face crises of identity, loss of a sense of purpose and, often, conflict and
communication problems now that they are forced to spend more time with family members.

These unsettling themes are widespread. These are seen as problems, but there is also opportunity there for people to examine their values and reorient themselves to society. The counseling community can be a significant part of this process, as it has been in the past.

Frank Parsons and his work in assessing individuals’ interests and abilities and matching them up with the community’s needs is one such example. The counseling profession grew out of this ethic and was informed and inspired by Carl Rogers and Abraham Maslow, whose lifelong dedication was to help individuals transform their lives by rising to meet life’s challenges and grow toward self-actualization. When people can engage in meaningful endeavors and apply their talents, individuals stand to benefit, as well as the larger society. The need now is great. By communicating a willingness to empathize with clients, competently address their religious beliefs and ultimately help transform suffering into new and better ways of being, counselors can offer a service that will promote healthy, whole people and, ultimately, a healthy, whole society.

The “nothing to lose” scenario can be dangerous. When the hardship of a major life event like a job loss is combined with household tension and conflict, people are at a heightened risk for harming themselves or others. Counselors should know the warning signs of such behavior. Stress and anger management are valuable tools. But counselors can go well beyond this. A skilled counselor can act as a mirror for anxious clients, helping them see themselves more clearly and look for ways to live that are more congruent with who they are really.

In a society where such great emphasis is placed on appearance and possessions, counseling sessions offer a place of solace. The therapeutic relationship can serve as a model for clients, who can learn to relate to the important people in their lives with greater honesty and integrity.

Julie Hammontree
Julie Hammontree is a resident of Greensboro, N.C., and a graduate counseling student at the University of North Carolina at Greensboro.

Name the population in this country that you feel is most underserved by the counseling profession, and explain what you think could be done to better address this group.

From the “Greatest Generation,” who lived the Depression and fought World War II, to the “Baby Boomers” born to that generation, older adults are the fastest-growing age group in the United States. Yet, the counseling profession is failing them. As America approaches the cusp of a
population revolution, we are unprepared to meet the mental health needs of older adults.

We cannot ignore our elderly, now approaching 15 percent of our population. America’s older adults are susceptible to an aggregate of mental health concerns, including multiple losses (death, health, employment and family roles), depression, financial strain, employment demands and environmental changes. This cacophony of issues amounts to crises for any individual, but especially so for the elderly who may, simultaneously, be physically frail, isolated, approaching dementia or facing end-of-life issues.

As with middle-aged America, today’s elderly are greatly concerned with access to quality health (including mental health) care. Access to mental health care for older adults, however, remains finite largely due to Medicare’s limited coverage. This access barrier may be temporary for, as this population increases and their power amasses to ignite policy change, their funding needs will likely, albeit somewhat belatedly, be realized. Although Medicare may currently be derelict in providing counseling services for most elderly, increased access is trickling into this clientele in two small streams — family counseling and veterans services.

American families have restructured in such a way that the two-parent, mono-ethnic, heterosexual couple head-of-household home is no longer mainstream. In respect to our present interest of the elderly, we note that, according to the AARP (1999), 6.3 percent of U.S. children under the age of 18 (approaching 4 million) now live in grandparent-headed households, and Kirby and Kaneda (2002) report that 38 percent of grandparent caregivers in the U.S. live below poverty. Meanwhile, we remain cognizant of the reasons behind the preponderance of grandparent-headed households: parental neglect, abuse, abandonment, criminal behavior, incarceration, drug abuse and death. Many of these children have experienced personal crisis and now reside with a grandparent who is also adjusting to an “off time” parental role. Ironically, mental health services may be made more available for the older adult due to family dysfunction, poverty, involvement of social services and consequent access to public assistance and health care.

In February 2009, the Department of Veterans Affairs approved the contracting of licensed professional counselors for mental health services. This expanded access, proposed to serve the inflated needs of the veterans and families of ongoing military actions, also potentially benefits a small segment of older veterans.

Regarding inequity in health care accessibility, it may be convenient to place the brunt of blame on Medicare restrictions. However, counseling professionals, individually and collectively, bear some responsibility. We now lack certification in gerontological counseling due to lack of interest; inasmuch, we have not met our ethical obligations to disengage from discrimination based on age … and socioeconomic status. We have not fully advocated for the well-being of our clients, especially as ACA Advocacy Competency domains advise us: “when individuals or vulnerable groups lack access to needed services.”

We must, as our Code of Ethics states, adequately train counseling students to meet the demands of the profession and to advocate for our clients without discrimination. We must study, practice and promote the counseling needs of the elderly and work diligently for Medicare reform. Take heart. Take action. Our elders need us.

References

Thomas J. Sherman

Thomas J. Sherman is a resident of Scottsville, Va., and a counseling graduate student at the University of Virginia in Charlottesville.

Should the national debate about health care reform include the delivery of counseling services as a covered treatment? Why?

The president and Congress are currently discussing how to improve health care, including how to make it accessible to the people and fiscally responsible. One of the considerations for inclusion in the health care reform bill is providing coverage for the provision of counseling services. By covering counseling services, individuals may increase their use of counseling services for prevention and early intervention. This increased use of counseling services, while costing money up front, can be a long-term cost-saving measure and provide support for domestic and foreign policy issues.

Preventative and early intervention counseling services can decrease overall health care spending, especially in acute care. Stress, depression and other chronic mental health issues can lead to both short-term and long-term somatic issues. By providing coverage for counseling services, it is possible to decrease future health care costs by helping teach coping skills or management of life issues before the manifestation of somatic complaints related to mental issues.

Increasing access to counseling services through health care coverage can improve work performance and lead to savings for individuals and businesses. It is estimated that loss of productivity due to mental health-related issues costs businesses $44 billion annually. By increasing productivity, individuals increase their earnings and the earnings of their business; this can lead to increased economic spending and job growth. Additionally, it can lead to a decrease in utilization of acute medical services, lowering the financial burden on health care providers.

The coverage of counseling services can also benefit school-aged children. As with adults, access to counseling can decrease the number of days that children are absent from school. The diminishing of days absent increases children’s access to knowledge, which will potentially lead to a more educated workforce. Research has indicated that higher educated individuals use more preventative health care, which leads to a decrease in usage of more expensive acute and emergency care.
Including counseling services coverage in health care reform can increase services to military personnel. As our service people return from combat, they face many counseling-related issues, such as the experience of transitioning back home, reintegration with their families, issues around post-traumatic stress, etc. Providing coverage for counseling services increases the ease of access to services and decreases the financial burden on our service people. These services could benefit the nation as a whole. They can help with soldiers’ transition back from war, which may increase their willingness to extend their military service, as well as helping prepare for redeployment.

Finally, by including coverage for counseling services in health care reform, it would raise the level of accountability in the field of counseling. The inclusion of counseling services in health care reform would encourage a re-examination of best practice and a closer look at the efficacy of our interventions. The funding of counseling services could prove to have a cyclical benefit. By increasing counseling’s accountability, it would increase the use of best practices, leading to improved health-related outcomes.

The inclusion of coverage for counseling services in a national health care plan would provide benefits in several different areas of national focus. It could decrease medicinal costs, increase worker and student productivity, assist our service people, as well as increase the accountability and strength of counseling services. Given the potential benefits to including the provision to cover counseling services, it seems like a critical piece of health care reform if we are interested in improving our nation.

The ACA Foundation congratulates the winners in this year’s Graduate Student Essay Contest and thanks all the other graduate students who took the time and effort to enter. It is through such thinking about counseling’s challenges that today’s counselors will be able to influence and improve counseling’s future.

Letters

Continued from page 8

of resistance, we find the smallest unit we are willing to do and do it. Or if we are unable to do even the smallest unit (a few seconds), we take a stand and take control by refusing to do anything. We do the smallest unit and then find something we love in the unit. We set up external triggers to keep us aware, not forgetting our focus (a change). And if we forget, we start up again each time we remember.

As counselors, we can assist clients in learning this process. As we make changes in our counseling process, we can use this strategy also. Resistance is our lifesaver and desire our change maker.

Edith D. Johnston, Ph.D., LPC, CRC
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Embracing the need for analysis

I hope you will promote more articles like Sara Schwarzbaum’s “Counselors don’t necessarily make good clients” (Reader Viewpoint, February 2010). I believe the professional development of a helping professional cannot exceed his/her personal development.

The training in another profession, psychoanalysis, supports this belief. The training consists of three parts: training analysis, clinical supervision and academic classes. These are listed here in order of importance to the development of an analyst. All analysts must go through analysis so their problems do not contaminate the analytic work with their clients. In my view, this is a good model for the helping professions.

Robert Dato, Ph.D., NCPsyA
Master Psychoanalytic Coach
Wynnewood, Pa.

Life span focus of career articles earns nod of appreciation

Congratulations on getting 2010 off to a super start with the January issue of Counseling Today. The major articles by Lynne Shallcross (“A voyage of self-discovery”) and Caitlin Williams (“The working worried,” reprinted from the National Career Development Association web magazine Career Convergence) were excellent, with a focus on viewing career development over the life span. It is rewarding to see this emphasis, because some of us have been advocating that concept for many years.

The January 2010 issue of the major magazine of our professional association sets a high goal for the next decade.

Carl McDaniels
NCDA President, 1973-1974

Editorial policy

Counseling Today welcomes letters to the editor from ACA members; submissions from nonmembers will be published only in rare instances.

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. Submissions can be sent via e-mail or regular mail and must include the individual’s full name, mailing address or e-mail address and telephone number.

ACA has the sole right to determine if a letter will be published.

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.

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Credit Card #____________________ Exp. Date ____________
CVC Code: AmEx (4 digits above credit card #) ___   ___   ___   ___
VISA, MC, Discover (last 3 digits next to signature line) ___   ___   ___
Cardholder’s Name (print) ______________________________________________
Daytime Phone________________________________________Date ____________
Authorized Signature ____________________________________________________

Shipping Address
Name _____________________________________Member No. ____________
Address __________________________________________________________
City________________________________ State______Zip ________________
Country___________________ Telephone (      ) ________________________
E-mail Address______________________________________________________

Credit Card Billing Address (if different from shipping address)
Name _____________________________________Member No. ____________
Address __________________________________________________________
City________________________________ State______Zip ________________
Country___________________ Telephone (      ) ________________________
E-mail Address______________________________________________________

Name on Certificate
Please print your name exactly how you want it to appear on the certificate.

Maximum 25 characters, including space and punctuation.

Shipping Address
Name _____________________________________Member No. ____________
Address __________________________________________________________
City________________________________ State______Zip ________________
Country___________________ Telephone (      ) ________________________
E-mail Address______________________________________________________

Credit Card Billing Address (if different from shipping address)
Name _____________________________________Member No. ____________
Address __________________________________________________________
City________________________________ State______Zip ________________
Country___________________ Telephone (      ) ________________________
E-mail Address______________________________________________________

Name on Certificate
Please print your name exactly how you want it to appear on the certificate.

Maximum 25 characters, including space and punctuation.

Payment Method
Total Amount $____________________ (U.S. funds only)
[ ] Check or money order payable to ACA in U.S. funds enclosed.
[ ] P.O. (attached) P.O. #____________________
[ ] VISA [ ] MasterCard [ ] American Express [ ] Discover
Credit Card #____________________ Exp. Date ____________
CVC Code: AmEx (4 digits above credit card #) ___   ___   ___   ___
VISA, MC, Discover (last 3 digits next to signature line) ___   ___   ___
Cardholder’s Name (print) ______________________________________________
Daytime Phone________________________________________Date ____________
Authorized Signature ____________________________________________________

Shipping Address
Name _____________________________________Member No. ____________
Address __________________________________________________________
City________________________________ State______Zip ________________
Country___________________ Telephone (      ) ________________________
E-mail Address______________________________________________________

Credit Card Billing Address (if different from shipping address)
Name _____________________________________Member No. ____________
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VISA, MC, Discover (last 3 digits next to signature line) ___   ___   ___
Cardholder’s Name (print) ______________________________________________
Daytime Phone________________________________________Date ____________
Authorized Signature ____________________________________________________
COMING EVENTS

NJCA Annual Conference
April 9-11
Lincroft, N.J.
Join the New Jersey Counseling Association at this year’s annual conference for professionals at all stages of their careers. There will be three full days of networking, panels, events and continuing education credits, including a presentation by keynote speaker Angela Duckworth on “Self-Control, Grit and Optimism as Predictors of Academic, Professional, Social and Health Outcomes.” For conference schedule and online registration, visit njcounseling.org.

Two Worlds Unite Symposium
April 10
Chapel Hill, N.C.
The sixth annual Two Worlds Unite Symposium will bring together national, state and local experts who have been successfully practicing integrated care. Topics at the conference, to be held at the University of North Carolina at Chapel Hill’s Friday Center, will include fiscal realities, health care reform, research and clinical tools. Barbara Mauer will present the keynote address. For more information, call 828.257.4475 or visit mahec.net.

MeCA Annual Conference
April 12-13
Rockport, Maine
The Maine Counseling Association is excited to bring two days of workshops ranging from refresher courses in group counseling and ethics to using technology in the counseling world. Our conference theme is “Counseling in the Digital World ... Keeping Our Students Safe.” Keynote speaker Alice Barr will give us tools to work with our students and clients in making them good digital citizens. Barr lives in Maine, where she is the high school instructional technology coordinator in a one-to-one laptop environment in the Yarmouth School District. Barr will address the issues facing our young people who are growing up online. For more information, visit maineca.org.

ACAM Annual Conference
April 15-17
Jefferson City, Mo.
The American Counseling Association of Missouri will hold its annual conference, themed “Counseling: Growth, Resilience and Healing,” at the Capital Plaza Hotel. Attendees are offered up to 20 CEUs through a wide variety of sessions for counseling practitioners in many specialties. Additional information, including prices and registration information, is available at counselingmissouri.org.

Trichotillomania Learning Center Annual Conference
April 23-25
Dallas
The Trichotillomania Learning Center announces its 17th Annual Conference on Compulsive Hair Pulling and Skin Picking. Fifty workshops will address issues related to hair pulling, skin picking and related behaviors. Learn about the latest research developments and treatment strategies for adults and children, from cognitive behavioral techniques to pharmacology to hypnosis. CEUs will be available. For more information, visit trich.org or contact Leslie Lee at leslie@trich.org or 831.457.1004.

CCA Annual Conference
April 30
Rocky Hill, Conn.
The Connecticut Counseling Association announces its upcoming Annual Conference, Counseling Connections 2010. Themed “Inspiring Hope During Challenging Times,” the conference will help colleagues connect with one another and explore new ways to work together, connect with strategies to help them navigate today’s realities, connect with counseling theory to hone their skills and connect with best practices they can use right now. For more information, e-mail ccapastpresident@ccamain.com.

DCA/DMHCA Conference and Workshop
May 1
New Castle, Del.
The Delaware Counseling Association and the Delaware Mental Health Counselors Association will jointly present a conference and workshop based on the theme “Resilience Across the Life Span.” Our luncheon speaker will be Rita Landgraf, Delaware’s secretary of Health and Social Services, and the afternoon workshop will focus on helping counselors to become more resilient. The conference will be held at the New Castle campus of Wilmington University. For more information, visit decounseling.org and click on the link for “2010 Conference.”

Annual School Counselor Update
June 22-25
Winona, Minn.
This program for school counselors’ professional and personal renewal, the 26th Annual School Counselor Update, will again take place on the campus of Winona State University. This year’s shorter, cost-saving format will include a keynote workshop on “Stress Reduction and Self-Care” to go along with the significant, structured and informal time to compare notes with colleagues about best school counseling practice. Earn one semester-hour graduate credit or 24 hours of CEUs. For additional information, call 800.242.8978 ext. 5337 or e-mail Tim Hatfield at thatfield@winona.edu.

NCDA Global Career Development Conference
June 29-July 2
San Francisco
Join more than 1,000 colleagues and friends at the premier conference for career development professionals across all areas of career development. Themed “A Bridge to a Brighter Future,” the National Career Development Association’s Global Career Development Conference will offer professional development discoveries through more than 90 sessions, 84 roundtables, eight Pre-Conference Professional Development Institutes, nine featured sessions, two amazing keynotes — Jason Dorsey of Gen Y Guy and Beverly Kaye of Career Systems International — and extraordinary networking opportunities. For more information, visit ncdag.org.
ASERVIC Professional Conference

Aug. 1-3
Myrtle Beach, S.C.

The Association for Spiritual, Ethical and Religious Values in Counseling invites friends and colleagues to its second Conference on Spirituality in Counseling: Navigating the Spiritual Journey of Life. The conference will be held at the Springmaid Beach Retreat and Resort. The goals of this conference are to provide practical information for mental health professionals as well as meaningful experiential activities for integrating spirituality into counseling practice across a variety of settings. Because hotel conference rates will be extended prior to and following the conference, we encourage you to include the conference in your family vacation. For details, visit springmaidbeach.com. For more conference information, visit aservic.org.

FYI

Call for submissions

The Louisiana Counseling Association invites submissions for the 2010 Louisiana Journal of Counseling. Research- and practice-based submissions related to the field of counseling and written according to American Psychological Association style will be considered for blind peer review. Submit an electronic copy to Meredith Nelson at mnelson@lsus.edu. Questions should be directed to Peter Emerson, editor, at pemerson@selu.edu or Meredith Nelson, coeditor, at mnelson@lsus.edu. ♦

NEWS & NOTES

Student-to-counselor ratios remain high

The ratio of students to school counselors in U.S. public elementary and secondary schools decreased slightly in the 2007-2008 school year, according to data released earlier this year from the U.S. Department of Education’s National Center for Education Statistics (NCES) and compiled by the ACA Office of Public Policy & Legislation. The data show the current U.S. student-to-counselor ratio is 467:1, down from 475:1 last year. The ratio is based on the total number of students enrolled in public elementary and secondary schools and the total number of “guidance counselors” employed in public schools during fall of the 2007-2008 school year, the most recent year for which data are available. ACA has the updated student-to-counselor ratio chart available on its webpage at counseling.org/PublicPolicy/TP/ResourcesForSchoolCounselors/CT2.aspx.

The overall number of students enrolled in grades preK-12 decreased in size from the 2006-2007 school year, with half of states showing a decrease in student enrollment. At the same time, the number of school counselors increased in most states. Fifteen states showed a decrease in the number of school counselors. According to the data, there were 105,519 counselors employed in U.S. public schools during the 2007-2008 school year and 49,292,507 students enrolled.

ACA recommends a maximum average student-to-counselor ratio of 250:1 to ensure that students have adequate access to counseling services. Research shows that the provision of school counseling services can improve student well-being and academic achievement. Based on data from NCES, only four states met ACA’s recommended ratio of 250:1 during the 2007-2008 school year: Louisiana, New Hampshire, Vermont and Wyoming. Illinois had the worst ratio in the United States, with one counselor for every 1,076 students.

You can calculate your school district’s student-to-counselor ratio for the 2007-2008 school year by visiting the NCES website at nces.ed.gov/ccd/districtsearch/ and entering in the name of your school district. Data on total students and total school counselors reported, among other information, will be available. To calculate the student-to-counselor ratio for your school district, divide the number of students by the number of counselors.

Please note that NCES collected this data during the 2007-2008 school year from state education agencies through its Common Core of Data (CCD) program. Under the CCD program, NCES annually collects fiscal and non-fiscal data about all public schools, public school districts and state education agencies in the United States. The data are supplied by state education agency officials and include information that describes schools and school districts, including name, address and phone number; descriptive information about students and staff; including demographics; and fiscal data, including revenues and current expenditures. For more information, visit nces.ed.gov/ccd.

Present at the 2011 ACA Conference & Exposition

Believe it or not, the countdown is already on for the 2011 American Counseling Association Conference & Exposition in New Orleans. ACA has issued a call for programs, and all proposals for Learning Institutes and Education Sessions must be submitted by June 2, 2010.

Learning Institutes, which will be held March 23-24, 2011, provide counseling professionals with opportunities to enhance their skills while earning continuing education credit. Three-hour and six-hour Learning Institute formats are available.

Education Sessions will be held March 25-27, 2011, and will include the following formats: 90-minute sessions, 60-minute sessions and 30-minute project/research poster sessions.

Prospective presenters must submit their proposals using the online form located at counseling.org/conference. The submissions form will be available beginning March 29.

A committee of professional counselors representing all ACA divisions and regions will review the proposals, and acceptance/rejection notices will be e-mailed by Aug. 12, 2010.

Call ACA Professional Learning at 800.347.6647 ext. 229 with questions regarding the submissions process. ♦
new role within the College. The position requires a person of vision with the ability to progress the School and enable it to acquire a sound academic profile within the discipline.

To apply for this position, please submit a cover letter, resume and transcripts by visiting the following website www.acap.expr3ss.com – a full job position description is outlined on the website.

Enquiries can be directed to Dr Ed Green, Dean, Australian College of Applied Psychology – ph: +61 29964 6363, email: ed.green@acap.edu.au. Applications close 16 April 2010 at 5PM Australian Eastern Standard Time.

MISSOURI

BJC BEHAVIORAL HEALTH

New Deaf Services Manager
Position includes to manage, coordinate, and supervise deaf and HoH clients with mental and emotional disorders through therapeutic and case management services. Build a strong community relationship between BJC Behavioral Health and the Deaf and HoH community through networking, advocacy and outreach efforts. Program Management/Coordination (50%) & Therapy (50%). Master or Doctorate in Counseling, Social Work, or Psychology. Job Experience: minimum 2 Years, 5-10 Years preferred. Supervisory Experience: Minimum 3 years, 5-7 Years preferred. Send resumes to Mark Stansberry, Executive Director BJC Behavioral Heath, 1430 Olive, Suite 400, St. Louis MO 63103
www.bjjobs.org (1000044)

NEW JERSEY

Caldwell College
Adjunct Instructor
Caldwell College’s Graduate Program in Counseling Psychology is seeking an Adjunct Instructor to teach the course “Techniques of Individual Counseling” two afternoons/evenings a week during the Summer 2010 Session B: June 22 to July 27.
PhD required, preferably in Counselor Education. The credential, Licensed Professional Counselor and prior teaching experience are also preferred. Candidates must be willing to support the Dominican, Liberal Arts mission of the College.
Caldwell College is a 4-year Catholic liberal arts college located in a suburban setting about twenty miles west of New York City. Founded in 1939 by the Sisters of St. Dominic, Caldwell College enrolls approximately 2,300 full time and part time students. Candidates must be willing to support the Catholic Dominican liberal arts mission of the College.
Review of applications will begin in February and continue until the position has been filled.
Send letter of application, resume, and contact information for three professional references to:
Caldwell College
Office of Human Resources – ACA
120 Bloomfield Ave
Caldwell, NJ 07006
FAX: (973) 618-3358
Email: resumes@caldwell.edu
Caldwell College is an EOE.
www.caldwell.edu

OREGON

LANE COMMUNITY COLLEGE

Faculty Counselor
Lane Community College in Eugene, OR is hiring for a full-time Faculty Counselor. The Counselor will provide teaching, career and personal counseling, and academic advising services to Lane Community College students and prospective students. They will serve as a member of an integrated instructional, counseling and advising team that provides services to academic divisions at the College and to undeclared and general transfer students through the Counseling and Advising Center. Requires a Master’s degree and 3+ years experience. Salary is $45,247 - $60,743 per academic year. Job closes 3/24/10. EEO/AA. Apply online at http://jobs.lanecc.edu

WASHINGTON

ANTIOCH UNIVERSITY SEATTLE

School of Applied Psychology, Counseling and Family Therapy
A core faculty appointment is open at Antioch University Seattle in the area of Mental Health Counseling Program in the School of Applied Psychology, Counseling, and Family Therapy beginning September 1, 2010. Antioch University Seattle faculty engage in teaching, research and service; the successful applicant will teach graduate courses, and supervise student research. This position is full-time (100% FTE), with a 12-month service period.
Applicants must have a Ph.D. (in Counselor Education and Supervision preferred) or equivalent doctoral degree in a related field with proven history of active participation in the counseling profession (counselor licensure, national counselor credential, active member of ACA and/or its divisions/branches), including strong training and experience with multicultural competency in counseling. Must be highly qualified for undergraduate, graduate teaching and independent research. All qualified candidates are encouraged to apply. The ideal candidate will complement and build on existing strengths within the school, and will be eager to interact with students and faculty from the broader community at Antioch University Seattle.
Antioch University Seattle is an affirmative action, equal opportunity employer. The University is building a culturally diverse faculty and staff and strongly encourages applications from women, minorities, individuals with disabilities and covered veterans. AUS is committed to supporting the work-life balance of its faculty.
If you have a question about the details of this search/position please contact the hiring unit directly. Thank you for your interest in this position at the Antioch University Seattle.
Positions pending budget approval.
Application Process: Complete and submit the following documents:
Cover Letter, Resume or Curriculum Vita, Application for Employment (Be sure to date and sign the Application for Employment. An incomplete application may delay action or disqualify you.) . Applicant Data Form, Names, addresses (including e-mail addresses), and telephone numbers of four references. References will not be contacted without prior approval of the candidate. Application/ Nomination Procedures: All applications or expressions of interest will be handled
Applications received before March 15, 2010 will receive higher priority. The position is expected to start no later than September 1, 2010. Choose one option for submitting your documents: E-mail: AUSHR@antiochseattle.edu, Fax: 206-441-3307, OR Mail: Search for Education Faculty c/o Human Resources, 2326 6th Avenue, Seattle, WA 98121

The final hiring process involves employment reference checks and a background check.

For accommodations to complete the application process, and/or if selected for an interview, please contact the Human Resources Department at 206-268-4022. TTY: 206-728-5745

The primary presenter must be an ACA member. All Education Session presenters must be registered for the Conference by January 1, 2011.

Confidentially until a list of individuals to be invited for interviews has been identified.

Visit counseling.org/conference for additional information.

Note: The primary presenter must be an ACA member.

All Education Session presenters must be registered for the Conference by January 1, 2011.
A counselor’s story…

8:00 a.m. Get to the office early. Start the coffee. Check voice mail. Leave a brief message for my client Brad. **Don’t want his wife over-hearing anything confidential.**

9:00 a.m. First client, Mark. Dealing with depression. Lost his job of 15 years. Body language anxious. **Admits he is contemplating shooting his ex-boss.**

10:00 a.m. Christine has a long-running drug and alcohol problem. Making great progress. **Offers to clean my house in return for counseling sessions.**

11:00 a.m. Mary gave me a big hug, again. She wants me to testify at her son’s child custody hearing. Let’s me know husband is going to subpoena her records. **She invites me to dinner.**

12:00 Grab lunch at desk. Check email. Sign up for CE class on crisis management.

Read an article on lawsuits filed over ‘client confidentiality.’ It is important to know when to protect a client’s privacy and when it’s required by law to report certain behavior.

**Just as important as having insurance coverage through HPSO!**

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“Dare to reach out your hand into the darkness, to pull another hand into the light.”
– Norman B. Rice

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