The power of group work

Also inside:
- Humor as a therapeutic tool
- Feedback-informed treatment
- A superficial model of self-care
The Counselors Professional Liability Insurance available through HPSO offers up to $1 million each claim (up to $5 million annual aggregate) of medical malpractice insurance, plus it pays your legal expenses.

- 66.7% of malpractice claims involve face-to-face counseling with the client
- 39.7% of allegations are due to ‘inappropriate relationship’ with the client
- 6.6% of licensing board complaints result in loss of license
- $11 million paid for counselors’ malpractice claims over 10 years

When you add up all the numbers, HPSO equals peace of mind.

*Understanding Counselor Liability Risk, NSO and CNA, March 2014.
Healthcare Providers Service Organization is a registered trade name of Affinity Insurance Services, Inc.; (TX 13695); (AR 100106022); in CA, MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services, Inc.; in CA, Aon Affinity Insurance Services, Inc., (CA 0G94495), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency.
Cover Story

30 Group effort
By Laurie Meyers
Counselors engaged in group work often marvel at the dynamic of “peer power” to effect change in clients’ lives.

Features

38 No laughing matter?
By Kathleen Smith
Counseling is serious business, but there is also something to be said for skillfully using humor as a therapeutic tool with clients, students and ourselves.

44 Knowledge Share
Incorporating feedback-informed treatment into counseling practice
By Sidney Shaw & Kirsten Murray
Collecting formal client feedback can help counselors check their assumptions about the quality of the therapeutic alliance and outcomes, increase the effectiveness of counseling and privilege the client’s voice.

Reader Viewpoint

52 Self-care in the world of empirically supported treatments
By Dolores “Lori” Puterbaugh
Is it possible that the frequently shallow practice of counselor self-care and the growing reliance on menu-driven, empirically supported interventions are not random parallel processes?
Does traumatic stress rearrange the brain’s wiring—specifically areas dedicated to pleasure, engagement, control, and trust? Dr. Bessel van der Kolk believes it does. He also believes these areas can be reactivated through innovative treatments including neurofeedback, mindfulness techniques, play, and yoga.

If you are looking for proven alternatives to traditional treatments—and new ways for survivors of trauma to reclaim their lives—this webinar is for you.

Bessel A. van der Kolk M.D. is an internationally recognized leader in the field of psychological trauma. He has been active as a clinician, researcher, and teacher in the area of posttraumatic stress and related phenomena since the 1970s. Dr. van der Kolk is past President of the International Society for Traumatic Stress Studies, Professor of Psychiatry at Boston University Medical School, and Medical Director of the Trauma Center at JRI in Brookline, Massachusetts. He has taught at universities and hospitals across the United States and around the world, including Europe, Africa, Russia, Australia, Israel, and China. His work integrates developmental, biological, psychodynamic, and interpersonal aspects of the impact of trauma and its treatment.

Can’t make the date and/or time? All ACA webinars are available to watch on demand for up to one year after purchase. Instructions will be included within your registration confirmation.

June 24, 2015
12:30-1:30 pm ET
1 CE: $29 members; $49 non-members
Register at counseling.org/webinars
Recognitions, intentional collaboration and recommendations

Robert L. Smith

The 2014-2015 year as the 63rd president of the American Counseling Association has moved at a rapid pace. It has been an honor to serve as your president during this fantastic year, highlighted by the ACA Conference & Expo in Orlando, Florida. Special for me are the relationships established during this time. My interactions with you have been both meaningful and humbling in the most positive sense. Memories of the dedicated professionals who are passionate about empowering others and the profession of counseling will be forever etched in my mind. Thank you!

Intentional collaboration both within and outside of the ACA community has been a theme during the past 12 months. It has been characterized by openness and honesty, yet tempered with the salient relationship conditions of respect, genuineness, congruence, caring, concreteness and understanding that we teach our students and that our mentors taught us. Collaborative experiences within and outside of ACA affirm that:

- The American Counseling Association is the home for individuals in the helping professions. ACA’s exemplary CEO, Richard Yep, is at the top of those serving in this position. And the ACA staff is the best—unbelievably competent and caring.
- Equifinality is alive and well, proving that we can find many options to the challenges facing individual members of ACA and its divisions, regions and branches. The creativity demonstrated by ACA members and leaders adds to the credibility of this concept.
- We have more in common than we have differences. We are dedicated to advocacy in its broadest sense for the fair and equitable treatment of all humans. We advocate for what is best for students, new professionals, practicing counselors, counselor training programs and the future of the counseling profession.

My recommendations pertaining to the future of the counseling profession include:

- Continued collaborative advocacy on behalf of all counselors with TRICARE (see p. 10), the Department of Veterans Affairs (VA) and licensure board rules and policies
- Continued collaborative advocacy for licensure portability
- Support and advocacy for the Council for Accreditation of Counseling and Related Educational Programs, the accreditation body in counseling that is nationally and internationally recognized by the Council for Higher Education Accreditation, the Institute of Medicine, the VA and a number of state licensure boards
- Support and advocacy for extensive grandparenting provisions for counselors to meet any changes brought about by federal and state agencies (again, see p. 10) and support for similar grandparenting provisions for counselor preparation programs to meet accreditation standards

It is important for all parties affected by the changes that are, and will continue, taking place in the counseling profession to look within and proceed prudently with those activities that will best benefit counseling and the future of our profession.

I close this column by welcoming Thelma Duffey as the 64th president of ACA. She will serve ACA very well because she is a leader, an innovator, a caring professional and a friend and colleague to us all.

Peace and happiness,
Robert L. Smith, Ph.D., NCC

Counseling Today

Counseling Today Staff
Publisher
Richard Yep
Associate Publisher
Carolyn C. Baker
Editor-in-Chief
Jonathan Rollins
800.347.6647 ext. 339
jrollins@counseling.org
Senior Writer
Laurie Meyers
800.347.6647 ext. 320
lmeyers@counseling.org
Staff Writer
Bethany Bray
800.347.6647 ext. 307
bbray@counseling.org
Senior Writer
Carlos J. Soto II
800.347.6647 ext. 377
csoto@counseling.org
Contributing Writer
Stacy Notaras Murphy
Advertising Representative
Kathy Maguire
607.662.4451
kmaguire@counseling.org
CT Column Editors
Washington Update
Art Terrazas
Counselor Career Stories
Danielle Irving
Private Practice Strategies
Anthony Centore
Risk Management for Counselors
Anne Marie “Nancy” Wheeler
Technology Tutor
Rob Reinhardt
Neurocounseling: Bridging Brain and Behavior
Lori Russell-Chapin & Laura Jones
Ethics Inquiries
Michelle E. Wade
Erin Stolsmark

Recognition, intentional collaboration and recommendations
MONTREAL
ACA2016
Conference & Expo

In partnership with the Canadian Counselling and Psychotherapy Association

Conference & Expo
March 31—April 3

- Pre-conference
Learning Institutes
March 30—31

- Palais des congrès de Montréal/
  Montréal Convention Center

- Learn more and register at
counseling.org/conference
A flurry of activity has taken place these past several months around your national ACA headquarters. I can remember in the “old days” when there was a bit of a lull for a few weeks after the annual conference. That was good because it allowed staff, leaders and members to take a deep breath, get organized and then prepare for the next project. But that was then.

As some of you know, after more than 30 years in the same location, ACA moved its headquarters to a building just down the block. Despite the short distance involved, this was a monumental task, requiring the concerted effort of all 60-plus staff members, as well as project managers, technology wizards and professional movers. Although the move was completed in November, we have continued to build, fix, assemble and “nest” in our new space. This past month, we finally had an official ribbon-cutting that included ACA President Robert Smith and the mayor of Alexandria.

This month, ACA launches its first Asia Pacific conference in Singapore, but it has been in the planning stages for several months. Although we won’t achieve nearly the number of attendees that we have for the ACA annual conference, the effort required to organize and work with those who live 12 time zones away has been both interesting and challenging.

In the midst of all of this, ACA has been very active on Capitol Hill, seeking to have licensed professional counselors included as independent practitioners under TRICARE (see p. 10). In addition, our advocacy on behalf of the Elementary and Secondary School Counseling Programs resulted in having funding restored after being threatened with zero dollars. While this was occurring on the federal level, our grass-roots and state legislative staffers were busy with various states’ “religious freedom restoration” bills and legislation concerning reparative “therapy” for minors.

Sometimes in life, things happen that can’t really be explained, yet they seem so prophetic. For instance, in the rush to get so much done, I found myself running over to the little deli near our office to grab something for lunch. I happened to buy one of those drinks that has some type of saying under the bottle cap. When I unscrewed the cap, there was only one word — RELAX. Was someone trying to tell me something or, given all that was happening, was it just a cruel joke? My thinking is that whatever the explanation, that bottle cap is a keeper.

Too often in our daily activities, we simply do not take the time to find a relaxing moment. I know I am preaching to the choir on this topic, but I strongly suggest that you follow the advice on my bottle cap. With the important work that all of you do, it is critical that you make the time to relax, recharge and reenergize. I hope you will remind your colleagues to do the same.

One example of this took place during the ribbon-cutting that I mentioned earlier. In my brief remarks, I said, “One last very special group of people I want to acknowledge are members of the ACA family who are in that esteemed category of being former or retired employees. The fact that so many of you are here today speaks volumes about your connection with the association. I thank you for joining us today, and I say, ‘Welcome home.’” Seeing so many of these former employees moved me and reminded me of the specialness of ACA. And that made me relax.

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

Be well.
A counselor’s view on mandalas and MARI

As a former student of art therapist Joan Kellogg, I was delighted to find an article about her work in the April issue of Counseling Today (Knowledge Share, “A visual picture of the human psyche,” by Michele Takei). I discovered Kellogg’s ideas following a challenging time in my life when I spontaneously began creating mandalas. I found her informal research into color, form and symbols in mandalas to be fascinating, and I have continued my exploration of mandalas ever since.

Kellogg’s schema of the Great Round resonates with my felt experience of life’s varying stages: ups and downs, with high and low energy, productivity and repose. The Great Round taught me that each and every life experience is worthwhile. Nothing is wasted; there are no dead ends. It encourages me to be patient and befriend myself. Embracing the concept of the Great Round, I have come to know the value of waiting and the importance of celebrating successes and letting the process unfold along more natural lines.

Although trained in the use of MARI (Mandala Assessment Research Instrument) cards, I have always preferred creating mandalas myself. The mandala designs of Kellogg’s Great Round are evocative, but there is insufficient research to clearly connect any image with a particular meaning. Although a connection between the color red and blood is compelling, the meaning of colors can be influenced by culture and individual experiences. For example, the color red can also signify flowers, birds, anger, sunset, sports teams or an Asian wedding dress. Therefore, a counselor cannot speak from a place of certainty about the meaning of a particular image or color.

When using a technique such as creating mandalas or choosing MARI cards and colors, we as counselors must remember that we are ethically bound not to force our ideas on clients. As a longtime teacher of creating mandalas, I encourage my students to prefacing their comments with, “If this were my mandala (MARI card, color choice), it would suggest to me ________.” The client is then invited to join: “I’m curious about your response to this.”

As counselors, we cannot interpret another’s experience. We can, however, witness, reflect, support, cherish and accompany our clients on their journey toward wholeness.

Susanne F. Fincher, M.A., LPC, ATR-BC, CPCS
Author, Creating Mandalas, The Mandala Workbook and Coloring Mandalas 1, 2, 3 and 4
CreatingMandalas@gmail.com

World isn’t quite ready for robot counselors

I am offering a rebuttal to the April Reader Viewpoint article, “The end of counseling as we know it,” by R. Rocco Cottone. I am a lover of all things technological, and I do see amazing possibilities for artificial intelligence, but there also appears to be an “uncanny valley” effect — a term that refers to the way that human beings become frightened when robots take on a human appearance that is too realistic (for example, see mashable.com/2014/06/24/japans-new-robots-are-scary/). I think the idea of robots as counselors would fall under this parameter.

In addition to the necessity of this first hurdle being cleared, anyone who has ever called customer service can remember the frustration of dealing with a robot. A person I know who was in customer service for a communications company said the most common statement they heard was, “Thank God I am finally talking to a human being.”

Although this frontier is exciting, the human aspect of counseling — such as helping people with phobias specific to technology — will need to be addressed by human beings. Not to mention that although ethical breaches happen with humans, no one can hack someone’s counselor ... unless that counselor is a robot.

Crimson S. Sorrels
CSSNVReno@yahoo.com

ACA adopts Competencies for Counseling the Multiracial Population

In March, the American Counseling Association Governing Council endorsed and adopted Competencies for Counseling the Multiracial Population. The competencies were developed by a task force made up of members of the ACA Multiracial/Ethnic Counseling Concerns Interest Network, co-chaired by Kelley R. Kenney and Mark E. Kenney.

The competencies are intended “to promote the development of sound professional counseling practices to competently and effectively attend to the diverse needs of the multiple heritage population,” including interracial couples, multiracial families, multiracial individuals, and transracial adoptees and families.

“This has truly been a labor of love for each of the authors who worked on this project over the past two years,” said Kelley R. Kenney. “We are proud of this accomplishment, and proud of ACA and the counseling profession for being the first helping profession to endorse and adopt these competencies.”

To access the competencies, go to counseling.org/knowledge-center/competencies and click on “Competencies for Counseling the Multiracial Population.”
**Seeing progress**

Thank you for the compassionate and informative cover story by senior writer Laurie Meyers about counseling the lesbian, gay, bisexual and transgender community (“Embracing the ongoing push for progress,” April). After so many years of seeing ads in Counseling Today from the military and Christian universities, both of which actively discriminated against gays and lesbians at one time, it is refreshing to see how much progress our profession and, in turn, our publication has made.

Frederic Tate
Williamsburg, Va.
Frederic.tate@dbhds.virginia.gov

**A recipe for licensure portability?**

Licensure portability is common in other health-related professions because their licensure boards require applicants to have graduated from a nationally accredited program and pass a uniform, national examination (“Addressing counseling’s portability crisis,” April). Licensure portability for professional counselors will be achieved when licensure boards require applicants to graduate from a nationally accredited counseling program, namely the Council for Accreditation of Counseling and Related Educational Programs (CACREP), and pass a uniform national examination, namely the National Board for Certified Counselors National Clinical Mental Health Counseling Examination (NCMHCE).

Scope of practice and professional identity are determined by training and competence. Licensed professional counselors who graduate from CACREP-accredited programs and pass the NCMHCE share a common scope of practice and professional identity.

Martin Ritchie
Martin.ritchie@utoledo.edu

---

**Coming next month**

- How counselors perceive technology’s impact on society
- Counseling survivors of campus sexual assault
- Profile of incoming ACA president Thelma Duffey
Major victory in sight for LPCs to practice under TRICARE

In April, Congress began work on H.R. 1735, the National Defense Authorization Act (NDAA) for 2016. This bill sets the policy and rules for our nation’s armed forces and all associated programs. As specifically requested by the American Counseling Association, the version of the NDAA being reviewed in the House of Representatives includes language that would create a true grandparenting process for licensed professional counselors (LPCs) to serve as independent practitioners under TRICARE, the health care program for military personnel, military retirees and their dependents.

ACA sought this change because it was apparent that too many LPCs would not be able to meet the transition requirements included in the final rule that TRICARE published in the summer of 2014. At the same time, there remains an overwhelming need for mental health clinicians to serve TRICARE beneficiaries. Revising and improving the final rule will allow more counselors the opportunity to help service members and their families, while also sustaining their counseling practices. In simple terms, this means there will be more mental health clinicians available to serve those who have served our nation. Those who wear the uniform have earned the best care that we can provide.

Changing the final rule to include a true grandparenting process for LPCs would mean that the counseling profession is fully integrated into the TRICARE health care program without exemption or bias. It would also indicate that counseling is respected for what it is—a scientific mental health discipline.

Although ACA is seeking a change to TRICARE, we still support accredited counseling programs approved by the Council for Higher Education Accreditation (CHEA). We encourage all counseling programs to meet that standard so that the profession can have an equitable training program for all counseling students.

The specific changes requested by ACA are consistent with our ongoing work with TRICARE on this issue. The new language would allow LPCs to be certified as independent practitioners under TRICARE (known as TRICARE-certified mental health counselors) as long as they:

- Possess a master’s degree in counseling (this will no longer be limited to only “clinical mental health counseling” or “mental health counseling”) from a CACREP-accredited or regionally accredited program (either a 48- or 60-credit-hour program)
- Are licensed to practice in their state
- Have practiced for at least five years in good standing

LPCs who meet these criteria would be grandfathered in under TRICARE until 2027.

ACA sought these changes because LPCs are being harmed through no fault of their own. As most counselors are aware, the profession is in a stage of transition. Although more programs are seeking and obtaining accreditation from CACREP (the Council for Accreditation of Counseling and Related Educational Programs), many of today’s qualified LPCs do not have a degree from a CACREP-accredited program. Some graduated before CACREP even existed, while others graduated when CACREP was still in its infancy. Whatever the circumstances, ACA cannot leave these LPCs behind as the profession begins to sail off to new horizons.

Realistically, counselors who graduated five years ago or longer and have met the requirements to obtain their licenses are unlikely to go back and obtain another degree or take yet another test to prove their competency. Counselors already have to take either the National Clinical Mental Health Counseling Examination or the National Counselor Examination for Licensure and Certification to obtain their licenses, and we do not believe there is sufficient rationale to enforce an additional requirement.

The biggest obstacle is that the current final TRICARE rule mandates that all LPCs must hold a degree in either clinical mental health counseling or mental health counseling, which are new designations in the industry. Thus, a practitioner who graduated with a degree in community counseling from a CACREP-accredited program, for example, would be barred from providing services under TRICARE, even if the practitioner holds a valid counseling license. Unfortunately, there is no path forward for these practitioners under the current rule.

Recent events have shown that members of the armed forces and their families desperately need increased access to mental health professionals. The signature wounds from our nation’s recent military conflicts are mental health wounds. Thus, the inclusion of LPCs under TRICARE is essential.

As a profession dedicated to delivering mental health services to everyone, we cannot allow exclusive policies to be instituted that prohibit qualified practitioners from delivering those services. We must move forward together. We must respect the work and sacrifices that all of our members have made to the profession while modernizing it.

ACA supports CHEA-approved accredited programs. At the same time, we do not want LPCs to suffer because certain avenues were not available to them. Our military service members have fought to protect our freedoms, and now it is time for us to do our part to protect them. We thank Congress for taking up this measure and hope that ACA members will join us in moving forward together. ACA will continue to fight for the counseling profession and the clients whom they serve. ♦
Ethical guidelines when working with groups

**Question:** My supervisor has asked me to conduct a group in my counseling agency geared toward adolescents who have been victims of sexual assault. How do I ensure that I am adhering to all ethical guidelines when starting a group of this nature?

**Answer:** There are many guidelines counselors need to follow when preparing for and conducting group work, especially with minors. The relevant standards from the 2014 ACA Code of Ethics are A.1.a., A.1.b., A.2.a., A.2.b., A.9.a., A.9.b. and B.4.a.

When working with groups, make sure group members understand that the group is the client. Therefore, your primary responsibility is to respect the dignity and promote the welfare of the group. Sexual assault is a sensitive subject. Be sure to address all possible risks with your supervisor in planning for this group to ensure that you are protecting the clients from any further trauma. Also, as a supervisee, you should look at standards F.1. (Counselor Supervision and Client Welfare) and C.2.a. (Boundaries of Competence). When working with survivors of sexual assault, you need to be competent and receive proper supervision for such a group. Make sure that you have the necessary training to conduct this group. If this is a new specialty area for you, consult with your supervisor to ensure your competence and to protect clients from potential harm. It may be important to research different curricula or educational materials for potential use and then pursue proper training to use them.

After you have begun the group planning process, it is important to screen the prospective group participants. Make sure the participants’ needs and goals are in line with the goals of the group and will not impede the group process. If a prospective group member is deemed not appropriate for the group, refer that individual to a different service or possibly a different group or counselor that will better meet the individual’s needs.

When conducting the informed consent process with minors, it is important to include the minor’s parent or legal guardian. The parent and client have the ethical right to choose whether they are comfortable being in the group setting. The adolescent and parent need to know that the purpose of the group is to process the adolescent’s own experiences and feelings about the sexual assault. This could be uncomfortable and difficult at times. Therefore, the parent and adolescent should be informed of any other possible limitations and potential risks.

Advise them about your goals for the group, the techniques and procedures that you will be using and the benefits of the group. Articulate to them your qualifications, credentials and relevant experience with this subject matter and clientele. Explain the importance of confidentiality, and also describe the limitations of that confidentiality. Inform them that your supervisor and possibly other team members from your agency will be involved in the group members’ care and may consult with you on the group process. If the client and parent agree to the terms, be sure that you have the proper documentation and parent signature on file. Also work with your supervisor to develop a fitting progress note template that can adequately depict the client’s progress in the group.

As always, a key to resolving any ethical dilemma is to consult with other counselors, refer to ACA standards and document the decision-making process and rationale for the decision so that you can provide an explanation if the decision is later called into question. It is also important to reflect back on any ethical decision to make sure that the decision was made effectively.

The question addressed in this column is an example of an ethical dilemma faced by counselors. This information is presented for educational purposes only. As a reminder, a benefit of ACA membership is personal ethical consultations through the ACA Ethics Department at 800.347.6647 ext. 314 or ethics@counseling.org.

Erin Stolsmark is the ethics chair for the South Dakota Counseling Association, a branch of the American Counseling Association. A licensed professional mental health counselor and national certified counselor, she works in private practice in Sioux Falls. She serves as co-editor of the Ethics Inquiries column with Michelle E. Wade.

Letters to the editor:
ct@counseling.org
Always do something special for your clients

A man goes to a restaurant and, at the end of the meal, he agrees to take a survey. The questions are as follows:

1) When you arrived, were you greeted by a host? Answer: Yes
2) Were you seated promptly? Answer: Yes
3) Was your server professional and courteous? Answer: Yes
4) Did your food arrive as you had ordered it? Answer: Yes
5) Were you satisfied with the quality of your meal? Answer: Yes
6) Was your check/bill correct? Answer: Yes
7) Would you recommend our restaurant to a friend? Answer: Maybe

What went wrong? Everything seemed to be going so well until the last question. This restaurant did everything right but missed the mark on one important factor:

When people go out to eat, they expect to be seated promptly. They expect the food to arrive as ordered. They expect the bill to be correct. This restaurant met the customer's expectations, but it failed to exceed them.

To have a restaurant — or any business — that is worthy of a customer's (or a client's) recommendation or referral, that business needs to offer something special. Some call it the “wow” factor. Others call it “surprise and delight.” Still others refer to it as being “notable.” At Disney, they call it “plusing” — the act of always adding a little something more to a guest’s experience.

What does special look like?

There's a restaurant outside of Boston where everyone receives a piece of blue cotton candy at the end of the meal. Two things I need to mention about this:

1) When you receive a bill at a restaurant, you've just finished a meal and probably also had dessert. The last thing anyone needs at this point is more food.
2) I've come to learn that cotton candy is 99 percent air. There's so little substance that it's practically a low-calorie food. Plus, it costs no more than a standard dinner mint.

So how do people respond to this offer? The food, service and ambiance at this particular restaurant are all exceptional. Still, what everyone talks about is a 5-cent piece of cotton candy: “That's so Americana! I haven't had cotton candy in years!” Just mention the neighborhood and people reply, “Have you been to XYZ restaurant — that place that gives cotton candy?”

What about the counseling?

When I mention the do-something-special concept to clinicians, a common question is, “Isn’t the most important thing the counseling?” My answer: Yes! If you're providing a counseling experience that is exceeding clients’ expectations, you will have no shortage of clients telling their friends how much they “need to schedule an appointment.” In addition, counselors who are charismatic, who invoke an emotional response from their clients or who are unusually effective in driving client change will build demand for their services faster than those counselors whose clients don't walk out of their sessions with their worlds rocked.

Some clinicians grow their practices because they are extraordinarily gifted. Others are just charming and enigmatic. Whether or not you like Dr. Phil, his charisma made him a blockbuster therapist. Clearly, there are ethical issues here. Even considering whether clinical care could result in referrals presents issues because one's clinical work should be focused solely on the success of the client.

A moving target

Although excellent clinical care is crucial, we would be remiss as counselors not to consider everything a client sees, hears, feels, smells and tastes when interacting with our practice. The process of doing something special is a moving target, however. Let me give an example.

Long ago, we installed glass-front beverage centers in the waiting rooms of Thriveworks centers to offer clients free soft drinks. Fast-forward seven years, and soft drinks had morphed from a whimsical treat to a public health pariah. We then stocked those beverage centers with bottled water — until bottled water went from being a luxury item to an environmental catastrophe. So we eventually removed the beverage centers.

There was a time when offering Wi-Fi in waiting rooms was exciting. Today, not only is it unimpressive, but few clients even use it because their cellular data plans and personal hotspots have made the need for it virtually obsolete.

As someone who is always striving to do something special for your clients, you need to constantly ask, “What’s next?”

Make a list

Offering something special can be expensive, but it doesn't need to be.
Imagine: Every client who visits your office gets his or her own private waiting area with a reclining leather chair, monitor and individual satellite radio station. Clients can dim, brighten or change the color of their lighting. The experience is private, personalized and … probably out of your budget.

If you’re thinking about offering something special for your clients, you’ll come up with lots of ideas, and some will be out of reach. That’s OK. It shows that you’re exploring lots of options. Also, instead of all the features mentioned above, perhaps a simplified offering of reclining leather chairs and privacy dividers is within your budget.

To start your list, here are some cost-effective ideas:

- Institute a late cancellation fee for the counselor. If you cancel a session with less than 24 hours’ notice, you pay your client a no-show fee.
- Call every client the day after his or her first session just to check in.
- Give every new client a copy of your favorite life improvement book.
- Give every client a “membership card” containing your direct contact information.

It requires continual effort to always be doing something special for your clients. Your colleagues might think you’re eccentric, but your clients will love your practice.

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

Letters to the editor: ct@counseling.org
Allostasis, stress and the microbiota-gut-brain axis

This month’s column is the first in a two-part series exploring how the bidirectional connection between our brain and gut helps us to achieve physiological stability and, in turn, supports our ability to regulate our emotions, thoughts and behaviors. We will further examine the influence of stress in this process and what counselors can do to support clients in this continually oscillating balance to enhance their mental, emotional and physical well-being.

Stress underlies virtually every counseling issue we face, ranging from the results of trauma, poverty, racism and abuse to decisional issues such as college choice, an argument with a loved one or career choice. At the same time, stress is necessary for learning and positive human development, both mentally and physically.

Homeostasis has become a limited concept and leads us to think that we can find a perfect balance. What we all need is a more realistic term, allostasis, as best defined by Bruce McEwen and John Wingfield: Allostasis is the process of achieving stability, or homeostasis, through physiological or behavioral change. This can be carried out by means of alteration in hypothalamus-pituitary-adrenal (HPA) axis hormones, the autonomic nervous system, cytokines or a number of other systems, and is generally adaptive in the short term.

Appropriate levels of stress, both physical and mental, strengthen us and lead to resilience. Negative stress, however, can tear us apart. It leads to a reduction in the size of our hippocampus (memory) and increases the size and negative activity in the amygdala, which is the primary site of the emotions related to fear (sadness, anxiety, anger). We have made the error of focusing only on the results of being overly stressed. Allostasis can also be defined as a healthy balance of calming and activation, or stimulation and quiet.

We believe that counseling needs to focus on allostasis and an active, changing balance as a central goal of therapy. We help clients by building intentional self-regulation through improving cognitive, emotional and behavioral skills. Vital in this process is increasing the strength of the prefrontal cortex for executive functioning and emotional regulation. Psychoeducation in the behavioral life skills is a vital supplement to traditional counseling.

We cannot learn, we cannot develop stronger muscles, we cannot strengthen our hearts and we cannot climb a high mountain (intellectual or physical) without a degree of stress involved. Change in counseling, particularly through the supportive challenge known as confrontation, builds appropriate stress and motivation for change. When stimulated, our perceptual senses of seeing, hearing, touching, tasting and smell are the basis of stress. This is a necessary precursor for the good things, but too much negative stimulation from trauma, poverty, abuse, bullying, harassment or repeated exposure to racism and other forms of oppression can lead to enduring brain change and dangerous bodily reactions. Social justice demands awareness, knowledge, skills and action to meet the needs of those who encounter the multiple forms of oppression and trauma.

Recent thinking has led to what is now being referred to as a sixth sense or second brain — the microbiota-gut-brain axis, which gives special attention to neuroinflammation. Evidence is now clear that emotional distress, as well as physical distress, can cause damaging inflammation. We associate the brain with production of serotonin, but 95 percent of this neurotransmitter is produced in the gut. Bodily stress from illness or other physical dysregulation has a profound impact on our brains, our thoughts and our emotions. Our total body reacts to external stressors. At the same time, internal cognitions and “gut feelings” produce our own internal stress.

In our column in the October 2014 issue of Counseling Today, we focused on the prefrontal cortex (PFC) as the seat of executive cognitive functioning and emotional regulation. We noted that the
PFC interacts with the more primitive amygdala, the energizer bunny that is key in our experience of all types of stress. The amygdala, which is activated by events in the external world and from internal bodily stimulation, is particularly sensitive to stress. The hippocampus, one of our memory structures, stores and distributes information throughout the brain. One of the key objectives of counseling is positive memory change, with the possibility of brain “rewiring.”

“Depression is as real a disease as diabetes.” This statement by Stanford University’s Robert Sapolsky is based on considerable research showing that psychological depression has a deep impact on the body. In turn, dysfunction of the body through diet and obesity, infection/inflammation and illness all lead to depression as well. Our cognitions, beliefs, emotions and behaviors can build bodily health, or they can be as toxic as illnesses or environmental pesticides. There is also a bidirectional feedback loop that can increase both depression and body reactions.

Additional research suggests, however, that positive attitudes and beliefs, exercise and healthy lifestyle choices affect the immune system in positive ways. For a very clear and practical background on depression and the body, we suggest watching Sapolsky’s lecture at youtube.com/watch?v=NOAgplgTxfc.

What might this mean for your practice?

Among neurocounseling’s implications for short-term and long-term daily practice:

1) Mental health and physical health are closely entwined. We recommend having a poster of the brain and body readily available for your clients. With certain clients, counselors might consider pointing out the relationship between the two and how the clients’ willingness to follow up on what they have learned in the interview can change them in positive ways. This should only be done with clients who show interest. Keep in mind that we are not physicians. Our work is counseling, prevention, education and referral.

2) Search for opportunities to help clients build stress resilience. Enable clients to balance inevitable and necessary reactions to stress with the ability to calm...
themselves. Help them develop and learn new ways to cope with more demanding stressors.

3) Bidirectionality (also known as cross-talk) is replacing linear thought in neuroscience/neurobiology and counseling. Allostasis reveals the bidirectionality of the interaction between the needed stress of stimulation and the need for calming. Too much emphasis in either direction can be problematic.

ANS: The key to stress resilience and allostasis

The autonomic nervous system (ANS) regulates the body’s unconscious actions of the heart, esophagus, lungs, stomach and gastrointestinal system. It consists of two divisions: the sympathetic nervous system, which is focused on response to stimuli and activation, and the parasympathetic nervous system, which is focused on calming and balance.

The ANS is connected to the brain stem in a bidirectional pattern. What happens in the brain affects both sympathetic stimulation (e.g., stress) and parasympathetic calming. In turn, bidirectional cross-talk means that action in the ANS affects the brain. Note that another way to think about stress is as activation that can be either strength building or destructive.

The calming and activating or stop-and-go actions of the ANS are repeated throughout the entire stress system by our neurotransmitters. For example, the neurotransmitter glutamate activates and makes learning possible, while GABA (gamma-aminobutyric acid) is necessary for balanced calming. Hormones in the brain and body interact with cytokines in positive and negative ways. Even in our gastrointestinal system, an interactive imbalance of highly diverse microorganisms (microbiota) can lead to poor mental and physical health, while a healthy gut, achieved through diet, exercise and a positive attitude, can improve our mental well-being. Through our listening as counselors, we tend to calm clients. Through reframing and confronting the discrepancies in their lives, we seek to activate change. Each of our counseling interventions has an impact on the holistic body and mind.

The ANS is also basic to the evolutionary process and thus needs to be considered first as we work with stress. For example, view the embryos of fish, mammals and humans. They all appear quite similar in the early stages of development. All have variations of the vagus nerve. Why? Heart function, eating and lungs are basic to survival and future development. Allostatic resilience — our counseling goal — ultimately affects the ANS and the entire body, including the brain. The higher body processes of allostasis represent later stages in the evolutionary process.

Stephen Porges’ polyvagal theory emphasizes the centrality of the vagus neural circuits for self-regulation. A critical role of the vagus nerve is providing the physiological basis of safety, coping with danger and avoiding life threat (as described by Ted Chapin in the November 2014 Neurocounseling column). Research has found that stimulating the vagal links to the amygdala not only calms but also facilitates memory of emotional or stressful events (see apa.org/monitor/apr04/vagus.aspx). Drawing from this, Porges provides specific suggestions to help clients deal with fight-and-flight sympathetic overstimulation. Most useful may be helping clients become aware of the power of unconscious body processing and how they can calm themselves through biofeedback, control of their heart rate, breathing exercises and the relaxation response, as well as providing neurofeedback.

Porges stresses safety needs and also emphasizes social skills and engagement training as it relates to clients becoming comfortable in social relationships. This action can be adapted and made more specific. For example, working solely...
This illustration shows the bidirectional cross-talk interconnections of the brain, gastrointestinal system and immune system. (Used by permission of authors Sue Grenham, Gerard Clarke, John F. Cryan & Timothy G. Dinan, “Brain-gut-microbe communication in health and disease,” December 2011 Frontiers in Physiology, journal.frontiersin.org/article/10.3389/fphys.2011.00094/full.)

Illustrating the microbiota-gut-brain axis

We discussed basic brain structures, neurotransmitters and the hormone-focused HPA axis in the October Neurocounseling column. Now we’ll turn to the second brain, the gastrointestinal system, which we will refer to simply as the “gut,” and which itself affects the development of the HPA. In turn, the gut is disturbed by imbalances in the ANS, the brain and by any external or internal stressor. Sapolsky makes it clear that our stress system is holistic and that the psychic distress reverberates throughout the body, just as illness does.

In the figure above, we see the reciprocal bidirectional cross-talk interconnections of the brain, the gastrointestinal system and the immune system, all connected by the ANS. The HPA axis generates and passes on hormones throughout the body. Important here is the production of cortisol, which is necessary for learning, but it is typically dysregulated in serious situations such as war, trauma, rape or the repeated traumas of bullying, poverty, racism and harassment.

In the second part of this series, we will explore in greater depth how stress influences this bidirectional connection and the implications of the ANS, vagus nerve and microbiota-gut-brain axis specifically for counseling practice.

As we look forward to next month’s article, consider the following:

1) Counseling not only changes the brain, it also has a meaningful impact on the body and its functioning. Our present skills and theories remain relevant in the new neuroscience/neurobiological world.

2) The National Institute of Mental Health is now giving major funding to a brain-based assessment and treatment framework. Thus, our attention to areas that our field has mostly ignored up to this point will likely be changing. In our opinion, counselor education and counseling and therapy practice will become more scientifically based. Introduce yourself to this coming new world by exploring the links at nimh.nih.gov/research-priorities/rdoc/index.shtml.

3) The material in this article is based on the most current research. We expect the connection between brain and body — and onward to key genetic factors — to become increasingly central in the literature.

Lori Russell-Chapin and Laura K. Jones serve as co-editors of the Neurocounseling: Bridging Brain and Behavior column. Contact them with comments, questions about neurocounseling or ideas for future columns at lar@fsmail.bradley.edu and Laura.Jones@unco.edu, respectively.

Allen E. and Mary Bradford Ivey are perhaps best known for their original work in microcounseling and microskills, as well as their continuing interest in multicultural counseling and therapy. They are now focusing on neurocounseling as a necessary factor in effective counseling but also showing how neurocounseling relates to social justice. Contact them at allenivey@gmail.com and mary.b.ivey@gmail.com, respectively.

Letters to the editor: ct@counseling.org
The ACA Center for Counseling Practice, Policy and Research is proud to offer Practice Briefs in which expert scholars in the counseling profession write brief, research-based summaries of best practices and empirically supported approaches related to a wide variety of concerns that counseling consumers bring to counseling. Each Practice Brief is a few pages in length and provides a variety of counseling approaches and web-based resources.

A nontechnical overview of the ACA Practice Brief on excoriation disorder is included in this article. The full Practice Brief — as well as many others on a variety of topics — is available at counseling.org/knowledge-center/center-for-counseling-practice-policy-and-research/practice-brief.

Have you ever looked in the mirror and thought, “What is this on my face?” Maybe it was a blemish, a slight imperfection or even a pimple. You may have given it little conscious thought, yet still started to pick at it ever so slightly.

But what if you couldn’t stop those picking behaviors? Let’s say that you start to experience scars, scabs and even excessive bleeding. Maybe you end up wasting large portions of your day picking at your skin, finding it more difficult to stop each time. This progresses, and you start picking more frequently and with greater intensity. Now you pick when you’re anxious or angry — or sometimes for no reason at all. One thing is certain: Although this experience may seem foreign, odd or even outlandish, it is an all too common occurrence for individuals with excoriation disorder (ED). ED, a new diagnosis in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), is characterized by recurrent and excessive picking, scratching or rubbing of normal skin. Also known as skin-picking disorder and dermatotillomania, ED falls under the DSM-5 heading of obsessive-compulsive and related disorders because of its genetic and symptomatic connection with obsessive-compulsive disorder (OCD).

Most people pick at their skin from time to time, but those with ED have an impulsive and persistent pattern of picking that progresses to the point of skin lesions and tissue damage. In most cases, these individuals feel unable to stop, and these behaviors interfere significantly with their ability to function optimally.

It is important to note that individuals with ED do not engage in picking behaviors because of a skin condition (for example, dry or itchy skin), drug or alcohol withdrawal, or another medical condition. They engage in these behaviors in an attempt to remove a perceived imperfection either on or underneath their skin. In many cases, individuals with ED will engage in picking with more frequency and intensity in response to intense emotions.

These impulses or compulsions are similar to those found in OCD. These impulses drive individuals with ED to remove an imperfection such as acne, scabs or other irregularities until the imperfection seems completely obliterated, ultimately exacerbating the imperfection. This type of skin picking is called focused picking. With focused picking, there is a building tension that leads up to the picking behaviors. Often, these individuals believe the only way to relieve their urge is to engage in the picking compulsion, similar to acting on a compulsion in OCD. Individuals who engage in this type of focused picking tend to avoid intense emotions and may pick as a means of relieving negative emotions such as sadness, worry or stress.

Although some individuals with ED are aware they are picking, others are not. When picking occurs outside of an individual’s level of awareness, the behavior is referred to as automatic picking. With automatic picking, individuals may pick while watching TV, reading or studying and may describe their picking experience as being in a trancelike state.

Individuals with ED may use their hands, mouths or even other objects such as tweezers or safety pins to pick multiple areas on their bodies (for example, face, arms, hands, chest, legs and back). In some cases, individuals eventually need antibiotics to treat infections and surgery to treat severe wounds. Additionally, this population often experiences feelings such as loss of control, embarrassment and shame regarding their behaviors. Frequently, these individuals have failed repeatedly in their attempts to decrease or stop these distressing behaviors.

Although individuals with ED often attempt to hide the physical evidence of skin picking (using bandages, clothing and makeup) from significant others, family members, friends and health professionals, these behaviors affect their social relationships and generally lead to periods of isolation. In addition to social...
Impulse control is defined by a tendency to engage in high-risk behaviors for pleasure-seeking purposes and without regard to the possible consequences. The pleasure an individual experiences during a picking episode is usually followed with embarrassment, guilt or shame, as is the case with most impulse-control disorders. This phenomenon can occur with both focused and automatic picking because both types can provide instant gratification. Individuals with ED may engage in both types of picking simultaneously or at different times within the same development or course of the disorder.

Individuals with ED experience a broad range of effects on functioning. These may include social impairment, such as embarrassment caused by visible lesions that may lead to isolation or avoidance of activities in which skin lesions could be exposed, and occupational impairment caused by excessive time spent picking, resulting in the neglect of job duties. Finally, lowered self-esteem may occur because of skin disfiguration or scarring, and intense frustration resulting from an inability to stop picking can lead to suicidal ideation or suicide attempts. Individuals with ED typically spend a great deal of time concealing their self-inflicted wounds and use cosmetic products, bandages or clothing to avoid questions regarding the origins of their wounds.

Unfortunately, ED is often overlooked by counselors or overshadowed by comorbid diagnoses. This is due in part to ED’s recent addition to the DSM-5, its similarities and comorbidities with other disorders, the lack of publicity surrounding ED and the shame and secrecy associated with the disorder. In general, ED is highly comorbid with OCD and other body-focused repetitive behaviors such as trichotillomania. In addition, ED is often comorbid with anxiety disorders, mood disorders, impulse-control disorders and substance-related disorders.

When diagnosing ED, counselors need to differentiate the behavior from nonsuicidal self-injury (NSSI). Whereas individuals with NSSI are typically motivated by intense, negative thoughts about themselves, the world or their future, individuals with ED are more fixated on or obsessed with the removal of unwanted imperfections.

**Treatment**

Individuals with ED generally demonstrate some insight into their behavior and usually want to stop picking. Often, they identify large periods of time dedicated to picking, thinking about picking or trying to resist picking urges. However, frequent attempts to reduce or resist picking urges have failed, thus requiring counseling treatment.

As is the case with most mental health disorders, the sooner an individual with ED engages in treatment — preferably before having these symptoms for more than a year — the higher the likelihood of recovery. However, because ED is often overlooked by counselors, clients and society in general, many individuals are unaware that help is even available.

Because of the lack of publicity about this disorder, more research on its treatment is necessary. Even so, it is important for counselors to be mindful of this diagnosis and familiar with treatment options so that clients who suffer from ED can find relief. Cognitive behavior therapy (CBT), acceptance and commitment therapy (ACT), habit

---

**Help Connect the Counseling Community!**

**Serve as Executive Editor or Associate Editor**

The *Journal of Professional Counseling: Practice, Theory & Research* is primarily technical and includes in-depth, researched articles. It is published biannually, mailed to all 7,200 members of the Texas Counseling Association, and abstracted online through EBSCO.

**EDITORS:** Volunteers for editorial positions serve 3-year terms. The Journal is managed via online review software.

**APPLICANTS:** Must belong to ACA or TCA and work as a professional counselor or counselor educator.

**SUBMISSIONS:** Requirements and complete details available at [www.txca.org/JournalEditor](http://www.txca.org/JournalEditor)
reversal training (HRT) and medication all appear to be effective strategies for aiding this population.

When using CBT, counselors help clients to identify, challenge and modify their distorted and dysfunctional thoughts related to their skin-picking behaviors. The first step usually consists of gathering information about the nature of the skin-picking behaviors (for example, frequency, location of picking, intensity and antecedents) and then exploring the psychoeducational component of the development and maintenance of unwanted behaviors.

Second, counselors highlight the automatic thoughts associated with these picking behaviors. For example, a client might express that because of a heated encounter with another employee, she should have the right to engage in picking behaviors. Furthermore, this client may express that relaxation is not possible without engaging in skin-picking behaviors (the client uses it as a coping mechanism). A counselor can aid this client by testing the validity of her maladaptive thoughts and attempting to replace them with more adaptive thoughts. For example, after the client’s belief is challenged, she may consider that even when she is highly upset, perhaps it is OK to feel that way and she can handle it. She may also conclude that after she picks, she feels horrible about herself, but after she takes a run on the treadmill, she feels significantly better about herself.

In addition to addressing thoughts and emotions, CBT also addresses the behaviors themselves. Three types of behavioral interventions useful with clients struggling with ED are preventive measures, activity replacement and relapse prevention. Counselors can assist clients by implementing preventive measures such as gloves, wraps or bandages to hinder and deter their ability to engage in skin-picking behaviors. These measures can also reinforce clients’ abilities to tolerate urges or serve as a distraction until urges decrease. Activity replacement helps clients to consider other, more adaptive, behaviors when their urges ensue. For example, when a client feels the urge to pick, he could consult a predetermined, practiced list of alternative behaviors (for example, cleaning, exercising or calling a friend) and substitute a more productive behavior for the picking behavior.

Ultimately, after clients implement these strategies, CBT involves preparation and strategies for overcoming future urges and reducing the likelihood of relapse.

ACT is another approach to apply when working with individuals with ED. ACT integrates acceptance, mindfulness and behavioral change strategies into counseling treatment. In early stages of the counseling process, counselors help clients to distinguish between urges to pick and actual picking behaviors. Once this distinction is made, counselors can then explore clients’ past attempts to control, resist and diminish picking behaviors. These clients often believe that they cannot tolerate the tension leading to picking behaviors and engage in picking as a means to relieve these uncomfortable urges and emotions. But this proves to be only an immediate, impulsive solution because their urges ultimately return. Through mindfulness-based techniques, ACT challenges clients to instead embrace these unpleasant emotions by noticing their emotional response, attempting to tolerate these emotions in the present and ultimately engaging in more adaptive behaviors.

HRT, another approach to use when working with this population, begins with awareness training. This involves describing the picking behaviors (frequency, intensity, duration) and the specific situations that lead up to the behaviors. In essence, HRT is an approach that increases clients’ awareness of their behaviors, develops alternative responses, reinforces those responses and generalizes these new behaviors to alternative situations. For example, a competing response needs to be versatile and ready in a host of client situations. A client might decide to clench his fist for two complete minutes each time an urge arises. After two minutes, the client can assess if he has other alternatives. If not, he can clench his fist for another two minutes. This is done until his urges either are more manageable or fully dissipate. The flexibility and availability of this alternative behavior is extremely accessible and practical. It is important to have clients reinforce their adaptive behaviors by rewarding themselves when they use these behaviors. This can be done through a token economy or contingency contract that the client establishes with the aid of the counselor.

Finally, medication is another effective measure used in the treatment of ED. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, fluvoxamine and escitalopram are often used in the treatment of ED. This may be because SSRIs have been shown to be effective in treating OCD and related disorders such as trichotillomania. However, although SSRIs are effective for some clients, these medications have demonstrated inconsistent effects across individuals. In addition to SSRIs, clients with ED may also respond to anticonvulsant medications such as lamotrigine. Regardless of the medication used, stand-alone medication is generally not as effective as medication used in conjunction with counseling treatments.

Counselors and other mental health professionals are instrumental in advocating for the increased awareness of ED, diagnosing the disorder when necessary and providing effective counseling treatment to address clients’ difficulties. Although relapse is always a concern, through the use of a comprehensive approach to treatment, many individuals with ED lead more adaptive and productive lives.

Matthew J. Paylo, a licensed professional clinical counselor supervisor, is an associate professor at Youngstown State University. In addition to having numerous publications on various clinical topics to his credit, he has more than 10 years of clinical experience. In his most recent book, Treating Those With Mental Disorders, which he co-authored with Victoria E. Kress, he addresses the diagnosis and treatment of excoriation disorder.

Alison A. Zins is a graduate student at Youngstown State University. She has written and presented on various clinical topics and is currently working as an intern at an outpatient mental health facility.

Letters to the editor: ct@counseling.org
ACA is delighted to announce a new e-book distribution partnership with Wiley.

Visit wiley.com/go/acaebooks to purchase our newest releases in Amazon Kindle, Apple iBook, VitalSource, CourseSmart, Wiley Custom Select, and other formats.
Counselor Career Stories – Interview by Danielle Irving

Transitioning to a career in counseling

Chris Depew is a graduate of the University of North Alabama and operates a part-time private counseling practice in Huntsville. In addition, he works full time as an accountant. Professionally, he sums up his passion as counseling, advocacy and recognition of the profession. Whenever Chris can find downtime, he enjoys fly-fishing and other outdoor activities with his family.

Danielle Irving: Tell us about your educational background. What courses were most helpful and influential during your master’s in counseling program?

Chris Depew: I have a bachelor’s degree in accounting and a master’s degree in community counseling. Two courses that I took in my graduate program that stand out as most influential are theories, which gave me the broad overview of many different styles and schools of thought in counseling, allowing me to find a fit for myself, and career counseling. Helping people plan for the future and work toward things that they want for themselves is fun for me.

DI: What does a typical workday look like for you?

CD: Currently, my workday can be hectic to say the least. It can be difficult to transition from corporate accounting to counselor overnight, and I found that to be the case for me. So, most days I work a regular day as an accountant and then in the afternoons and evenings, I see clients in my private practice. On occasion, when they need me, I also do assessments and group work with a regional inpatient and outpatient addiction treatment center.

DI: What does a typical workday look like for you?

CD: While exploring ministry, I came across resources on counseling ministries, and from there I knew that I needed to be in counseling and not in ministry.

DI: What led to your choice to pursue a second career in counseling, on top of your career in accounting?

CD: While I had a successful career in accounting, it was just never who I was. Sometimes it takes doing something for you to figure out that you really are not a fit for it. So, it began from there and led me down a path where I explored ministry as a second career.

While exploring ministry, I came across resources on counseling ministries, and from there I knew that I needed to be in counseling and not in ministry.

DI: What does a typical workday look like for you?

CD: Currently, my workday can be hectic to say the least. It can be difficult to transition from corporate accounting to counselor overnight, and I found that to be the case for me. So, most days I work a regular day as an accountant and then in the afternoons and evenings, I see clients in my private practice. On occasion, when they need me, I also do assessments and group work with a regional inpatient and outpatient addiction treatment center.

DI: What organizations or associations have been most helpful to you in the counseling profession?

CD: While in graduate school, I was involved with the Alabama Counseling Association and the Alabama Mental Health Counselors Association. They helped me meet people in the field and network with others who could help me through school and beyond. I served as treasurer of the Alabama Mental Health Counselors Association for two years while in graduate school. Since graduation, I have utilized the American Counseling Association more and more. The resources they provide are fantastic.

DI: What are your goals and plans for the future in this field?

CD: I have some short-term goals, and then I have longer-term goals. For the short term, I want to be able to have enough clients in private practice where I can make the transition to full-time counselor, then complete the remaining hours of my associate licensed counselor so I can become a licensed professional counselor.

Longer-term goals include expanding my practice, becoming an associate licensed counselor supervisor and working full time and driving 100 miles just to attend night classes. My successes are just as much my wife’s and daughter’s as they are mine. Aside from that, I am motivated by people and the strength that I see in them, even when they can’t see it in themselves.

DI: What organizations or associations have been most helpful to you in the counseling profession?

CD: While in graduate school, I was involved with the Alabama Counseling Association and the Alabama Mental Health Counselors Association. They helped me meet people in the field and network with others who could help me through school and beyond. I served as treasurer of the Alabama Mental Health Counselors Association for two years while in graduate school. Since graduation, I have utilized the American Counseling Association more and more. The resources they provide are fantastic.

DI: What are your goals and plans for the future in this field?

CD: I have some short-term goals, and then I have longer-term goals. For the short term, I want to be able to have enough clients in private practice where I can make the transition to full-time counselor, then complete the remaining hours of my associate licensed counselor so I can become a licensed professional counselor.

Longer-term goals include expanding my practice, becoming an associate licensed counselor supervisor and...
obtaining my Ph.D. in counseling education so one day I can teach the next generation of counselors.

**DI:** If you could start your career over again, what would you do differently?

**CD:** In my counseling career, I wouldn't do anything differently. If I could change my career from the very beginning, I would have listened to myself way back in second semester of my freshman year of college. I said that I wanted to pursue psychology, but I didn't find much support in the decision from family, so I decided to change paths.

**DI:** What would you suggest to someone who is just beginning in the counseling field?

**CD:** I would tell someone new to the field to surround yourself with people in the field — people who are new like you and people who have been in this field for years. You need community; counselors need each other.

The other thing would be to never stop learning. You should constantly be working or reading a book or doing research about something in the field.

Maybe one other thing: Take some chances to obtain what you want. Don't let anyone tell you something is impossible.

**DI:** ACA has more than 55,000 members. Is there anything I have left out that you want our readers to know about you or your work?

**CD:** I don't really have anything else. I will say that I am always looking for an adventure and that I look forward to meeting and connecting with as many of the 55,000 members as I can throughout my career.

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

Letters to the editor: ct@counseling.org

---

**NEW EDITION!**

**Solution-Focused Counseling in Schools**

Third Edition

John J. Murphy

“This book does a wonderful job of translating the philosophy and principles of solution-focused counseling into practical terms that school counselors can use. Dr. Murphy draws from his extensive background in writing a book that is personal, academically sound, and interesting. I highly recommend this revised edition to all mental health professionals.”

—Gerald Corey, EdD, ABPP

Professor Emeritus of Human Services and Counseling

California State University, Fullerton

The third edition of this widely adopted text covers both the philosophical foundations and nuts-and-bolts essentials of using solution-focused counseling to help preschool–12 students resolve problems.

This edition includes new chapters and information on the restrictive influence of problems on people's thinking, strategies for positive relationship building, collecting client feedback to monitor and improve counseling services, and coconstructing solvable problems and reachable goals. Real-life case examples, sample dialog from counseling sessions, discussion and practice exercises at the end of each chapter, troubleshooting tips, and new and expanded appendixes enhance classroom and clinical utility. A complimentary test manual and PowerPoint slides for instructors' use are available by written request to ACA.


List Price: $58.95 | **ACA Member Price: $46.95**

Shipping and Handling: $8.75 ($1.00 for each additional book)

Order Online: counseling.org/bookstore

By Phone: **800-422-2648 x222** (M-F 8 a.m. – 6 p.m.)
In this classic casebook, counseling ethics luminaries Barbara Herlihy and Gerald Corey teach readers to ask the important questions and apply salient ethical standards in the context of real-world ethical predicaments. This practical guide is ideal both for teaching future members of the profession about their ethical responsibilities and for reinforcing ethical competence among current professionals. We strongly recommend this guide.

Jeffrey E. Barnett, PsyD, ABPP, Loyola University Maryland
W. Brad Johnson, PhD, United States Naval Academy
Coauthors, Ethics Desk Reference for Counselors, 2nd Edition

Herlihy and Corey’s text boosts the reader’s ethical understanding leaps and bounds above mere reading of the ACA Code of Ethics. With multifaceted case study examples and an integrated approach to tackling ethical dilemmas, this book is a must-read for students, counselors, counselor educators, and supervisors.

Shannon Hodges, PhD, Niagara University
ACA Ethics Revision Task Force Member
Michael Knight, Graduate Student, Niagara University

The seventh edition of this top-selling text provides a comprehensive resource for understanding the 2014 ACA Code of Ethics and applying its principles to daily practice. Each individual standard of the Code is presented with an explanatory case vignette, and a Study and Discussion Guide is provided at the beginning of each major section of the Code to stimulate thought and discussion. Common ethical concerns, with instructive case studies, are then explored in individual chapters. Topics addressed include client rights and informed consent, social justice and counseling across cultures, confidentiality, counselor competence, working with minor clients, managing boundaries, client harm to self or others, counselor training and supervision, research and publication, and the intersection of ethics and law. Chapters new to this edition examine managing value conflicts and the issues surrounding new technology, social media, and online counseling. The Casebook also contains an Inventory of Attitudes and Beliefs About Ethical Issues to assist counselors in developing a personal ethical stance.

List Price: $72.95 | ACA Member Price: $49.95

Shipping and Handling: $8.75 ($1.00 for each additional book)

Order Online: counseling.org
By Phone: 800-422-2648 x222 (M-F 8 a.m. – 6 p.m.)
Reporting clients who are a ‘clear and present danger’

**Question:** A colleague told me that some states are now requiring counselors and other mental health professionals to report certain clients to a designated government agency if they believe that the clients may be a danger to self or others. This seems to go beyond the Tarasoff-type reporting (Tarasoff v. Regents of the University of California) that has been in effect for years. The colleague told me that the new state laws are designed to prevent potentially dangerous mental health patients and clients from being able to obtain firearms. Is this true?

**Answer:** Some states have passed such laws imposing requirements on certain counselors and other mental health professionals. For example, the state of Illinois now requires mental health facilities, physicians, psychologists and “qualified examiners” to report persons whom they have determined to be a “clear and present danger” to themselves or to their communities. Such reports must be made to the Illinois Department of Human Services Firearm Owners Identification Mental Health Reporting System within 24 hours of the determination.

Additionally, in some circumstances, physicians, licensed clinical psychologists and qualified examiners who determine a person to be developmentally disabled or intellectually disabled are also obligated to report the person within 24 hours of the determination. Among those included in the definition of qualified examiner is “a licensed clinical professional counselor with a master’s or doctoral degree in counseling or psychology or a similar master’s or doctorate program from a regionally accredited institution who has at least three years of supervised post-master’s clinical professional counseling experience, which includes the provision of mental health services for the evaluation, treatment and prevention of mental and emotional disorders.” (See [dhs.state.il.us/page.aspx?item=69505](http://dhs.state.il.us/page.aspx?item=69505) for further explanation of the law and reporting duties.)

Under the Illinois law, immunity from a lawsuit is provided to the reporter except in cases of willful or wanton misconduct. Additionally, certain school administrators are also subject to reporting requirements, although the mechanics are somewhat different.

New York state was at the forefront of this type of legislation in early 2013, following the Sandy Hook Elementary School shooting in nearby Connecticut. However, the New York law did not specifically include counselors. Counselors are advised to monitor legislation in their own states to see if similar duties might arise in the future.

The question addressed in this column was developed from a de-identified composite of calls made to the Risk Management Helpline sponsored by the American Counseling Association. This information is presented for educational purposes only. For specific legal advice, please consult your own local attorney. To access additional risk management Q&As, go to [counseling.org/ethics](http://counseling.org/ethics) and scroll to the bottom of the page for the ACA members-only link to the Risk Management section of the website.

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

Letters to the editor: 
ct@counseling.org

---

**STUDY GUIDE REVISED**

**2015 7th EDITION**

Dr. Andrew Helwig’s *Study Guide for the National Counselor Exam and CPCE* has been revised. All eight CACREP content areas have been revised and new information addresses the DSM-5 and the revision of the ACA Code of Ethics. New material also includes neurobiology, dialectical behavior therapy, mindfulness, distance and technology counseling, and wilderness therapy. This comprehensive and user-friendly 400+ page guide also has exam-taking tips, study strategies & 2 practice exams. Order or download your copy ($89.95). Workshop DVDs available also. Order at: www.counselorprep.com.
Recent Book Releases

Newer titles of interest to the counseling community

**Psychoanalytic Approaches for Counselors**
By Frederick Redekop, SAGE Publications

This book explores Sigmund Freud’s historical contributions to the theories within this school of thought and demonstrates their practical application in clinical practice today. Using the compelling framework of the common factors approach, the text helps readers consider how both the client’s perspective and the interpersonal forces within a helping relationship can shape positive therapeutic outcomes. The text’s clinical vignettes, case examples and discussion of significant updates within the field further highlight the relevance of the psychoanalytic approach to counseling.

**The Therapeutic “Aha!: 10 Strategies for Getting Your Clients Unstuck**
By Courtney Armstrong, W.W. Norton & Co.

This book explores the thrilling and rare moment when clients reach an elusive realization, allowing them to make meaningful change. In 10 straightforward strategies, this practical book demonstrates how to shake things up in therapy when a client is stuck or stalled to jump-start progress. Readers will learn how to spark the “emotional brain” — the part of the brain that houses automatic, unconscious patterns — and create new neural pathways that engage and advance the healing process. Divided into three parts — awakening a session, healing emotional wounds and activating experiential change — the book walks readers through specific techniques.

**Handbook of Life Design: From Practice to Theory and From Theory to Practice**
By Laura Nota & Jerome Rossier, Hogrefe Publishing

Our lives and careers are becoming ever more unpredictable. The life-design paradigm described in detail in this groundbreaking handbook helps counselors and others meet people’s increasing need to develop and manage their own lives and careers. Life-design interventions, suited to a wide variety of cultural settings, help individuals become actors in their own lives and careers by activating, stimulating and developing their personal resources. This handbook first addresses life-design theory, then shows how to apply life designing to different age groups and with more at-risk people. It also looks at how to train life-design counselors.

**Cognitive Behavioral Therapy in K-12 School Settings: A Practitioner’s Toolkit**

Twenty percent of school-age children in the United States experience mental health issues each year, and cognitive behavioral therapy (CBT) is one of the most effective and empirically supported interventions to address these needs. This practical, quick-reference handbook is for mental health professionals in the K-12 school setting who are seeking a hands-on guide for practicing CBT. Based on a wealth of research supporting the efficacy of CBT with school-age children, it features specific interventions that can be applied immediately and is tailored to the needs of busy counselors, school psychologists and social workers.

**Love: Helping Children Embrace Love**
By Esther Adler, Bright Awareness Publications

The latest book from the innovative ColorFeeling series joins Anger, Sad, Happy and Jealous to help children explore and express their feelings. The author, a licensed mental health counselor, wrote the series as a therapeutic tool for counselors to use when working with children who need help expressing their feelings. Utilizing vivid illustrations, child-friendly animal characters and crisp text, this book teaches children how to identify feelings of love, explore typical situations in which they can experience love and integrate practical examples of embracing love. Like the other books in the series, Love is interactive and contains worksheets.

**No Time for Tears: Coping With Grief in a Busy World**
By Judy Heath, Chicago Review Press

Facing the loss of a loved one in a death-avoidant culture can feel impossible to handle, especially in our interconnected and digitally social world. Told through the voice of a practiced therapist, this book is a new kind of guide, rich with information and real-life stories to help not only people...
struggling through grief but also those who counsel them. The author draws on her experiences in private practice, including her role in counseling people affected by 9/11. She also shares her own story of loss, as well as years of research to address misconceptions, myths and misinformation about grief.

**Creative Interventions With Traumatized Children, Second Edition**
Edited by Cathy A. Malchiodi, Guilford Press

A trusted, best-selling resource, this volume demonstrates a range of creative approaches for facilitating children’s emotional reparation and recovery from trauma. Experts in play, art, music, movement and drama therapy, as well as bibliotherapy, describe step-by-step strategies for working with children, families and groups. Rich with case material and artwork, the book is both practical and user-friendly. Specific types of stressful experiences that are covered include parental loss, child abuse, family violence, bullying and mass trauma. Important developments in neurobiology, self-regulation, resilience and posttraumatic growth are highlighted in this substantial revision.

**Thriving Under Stress: Harnessing Demands in the Workplace**
By Thomas W. Britt & Steve M. Jex, Oxford University Press

This book emphasizes how stress on the job can be used to promote personal growth and well-being. It illuminates the ways that stressful working conditions can produce positive outcomes when employees approach demands in the right way, focus on the meaning and significance of their work, and recover appropriately from stressful working conditions, both during the day and when at home. The authors encourage employees to view themselves as active constructors of their work environment — capable of proactively addressing the burdens they encounter instead of becoming passive recipients of work stressors.

**Group Counseling With LGBTQI Persons**
By Kristopher M. Goodrich & Melissa Luke, American Counseling Association

This unique resource provides strengths-based, group counseling strategies designed to meet the needs of lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI) clients in a variety of settings. The authors capture the developmental concerns of LGBTQI individuals throughout the life cycle as they establish and maintain intimate relationships, create families, encounter career concerns and navigate other milestones and transitions. Illustrative case examples and interventions throughout the text, as well as warnings and recommendations, make this an ideal resource for practice and group work courses.

**Kid First Divorce Treatment Program: A Facilitator’s Guide for Group Work With Children**

**Teen First Divorce Treatment Program: A Facilitator’s Guide for Group Work With Adolescents**

**Teen Survival Guide to Parent Divorce or Separation: A Teen First Self-Guided Workbook**
By Jeremy D. Jewell, Research Press Publishers

The author has drawn on his years of research and clinical practice to develop the one-of-a-kind group practices described in these resources. The two facilitator’s guides detail procedures for conducting engaging and age-appropriate group sessions to help children and adolescents adapt quickly to the changes brought about by parental divorce or separation. The guides have everything needed to facilitate the program, including a full script and outline for each session, and handouts for group members and parents. The workbook is a helpful adjunct to the **Teen First Divorce Treatment Program** facilitator’s guide, covering the same topics as the group sessions.

**The Therapist’s Ultimate Solution Book: Essential Strategies, Tips & Tools to Empower Your Clients**
By Judith A. Belmont, W.W. Norton & Co.

Clients go to therapy wanting to change but often have no inherent knowledge of how to change. It’s up to the therapist to build a well-stocked toolkit of life skills and psychoeducational strategies. This book delivers an array of basic “solutions” — in the form of handouts, worksheets, exercises, quizzes, mini-lessons and visualizations — to help clients feel empowered to take charge of their lives. Chapters are organized around the most common issues seen in therapy, such as stress, anxiety, low self-esteem, depression and interpersonal conflict. Packed with resources and client stories, it is a one-stop shop of educational techniques.
Instructive DVDs for Your Practice or Classroom

Rooted Sorrows—Emotional Burden to Emotional Health: Veterans With PTSD
presented by Mitchell Young

In this compelling and heart-wrenching DVD, Mitchell Young, a licensed psychotherapist and combat veteran who has counseled Vietnam veterans for more than 15 years, discusses PTSD and the lasting effects of combat and severe trauma. Drawing from his own experiences in Vietnam as a member of the Marine Corps, he examines the emotional scars that occur after a traumatic event, night terrors, chronic isolation, emotional numbness and complex and secondary PTSD. Produced by R-Squared Productions, LLC • 2010 | 50 minutes | DVD Order #78241

List Price and ACA Member Price: $59.95

Breakthrough: Art, Analysis, & the Liberation of the Creative Spirit

This inspiring film captures the experience of eight artists of varying ages who have been in therapy. It demonstrates the growth and freedom made possible by facing the pain that both psychoanalysis and creativity can bring to awareness. The artists in Breakthrough—a sculptor, a writer, a musician, three painters, and two visual artists—had found themselves held back in their lives and work because of traumatic events and unresolved emotional issues from the past. Through moving scenes that examine their individual therapeutic issues and healing process, the DVD shows how the combination of therapy and creative work liberated them professionally, emotionally, and spiritually. Sponsored by the Lucy Daniels Foundation. Produced by Expressive Media, Inc. • 2011 | 50 minutes | DVD Order #78242

List Price and ACA Member Price: $59.95

Practical Strategies for Caring for Older Adults: An Adlerian Approach for Understanding and Assisting Aging Loved Ones
presented by Radha Janis Horton-Parker and R. Charles Fawcett

This DVD offers caregivers, counselors, and educators effective strategies to improve the lives of older people. Horton-Parker and Fawcett discuss the characteristics of older adults, followed by typical situations encountered by caregivers. Engaging vignettes and presenter commentary illustrate the underlying needs and mistaken goals of attention seeking, power, revenge, and assumed inadequacy that often cause perplexing behavior in older people. The presenters’ simple techniques create win-win situations between caregivers and aging loved ones that improve the quality of life. • 2010 | 120 minutes | DVD Order #78238

List Price: $119.95 | ACA Member Price $99.95

Quality Circle Time in the Secondary School
presented by Jenny Mosley

In this DVD, Jenny Mosley presents her classroom behavior management model Quality Circle Time, which encompasses a whole-school approach to enhancing self-esteem and building positive relationships. Through exercises with a group of students, she teaches the skills, crucial steps, and key ground rules essential to effective circle time. The group session is followed by a teacher question-and-answer session. Includes a PDF of Mosley’s book Important Issues Relating to the Promotion of Positive Behavior and Self-Esteem in the Schools, as well as lesson plans and discussion points. Produced by Loggerhead Films • 2010 | 60 minutes | DVD Order #78240

List Price and ACA Member Price: $129.00

Bullying in Schools: Six Methods of Intervention
presented by Ken Rigby

Ken Rigby, an international expert on peer victimization, gives clear, practical guidance on how to prevent and respond to bullying in high schools. Using actors and role play, the DVD features a typical bullying scenario and then demonstrates how the following six methods can be applied to the situation: the Disciplinary Approach, Restorative Practice, Strengthening the Victim, Student Mediation, the Support Group Method, and the Method of Shared Concern. By showing the advantages and weaknesses of each method, the counselor or teacher can see how each possible solution might work. Includes a PDF with a summary of important information and discussion guidelines. Produced by Loggerhead Films • 2009 | 35 minutes | DVD Order #78239

List Price and ACA Member Price: $129.00

Please include $8.75 for shipping of the first DVD and $1.00 for each additional DVD.

Order by phone: 800-422-2648 x222
M–F, 8 a.m.–6 p.m., ET

Order online: counseling.org/publications
Sensorimotor Psychotherapy: Interventions for Trauma and Attachment
By Pat Ogden, W.W. Norton & Co.

Written for therapists and clients to explore together in therapy, this companion book to the author’s popular Trauma and the Body: A Sensorimotor Approach to Psychotherapy, is a practical guide to the language of the body. The body’s intelligence is largely an untapped resource in psychotherapy, yet the story told by the “somatic narrative” — gesture, posture, prosody, facial expressions, eye gaze and movement — is arguably more significant than the story told by the words. The language of the body communicates implicit meanings and reveals the legacy of trauma and of early or forgotten dynamics with attachment figures.

APA Dictionary of Psychology, Second Edition
American Psychological Association

This second edition of a landmark reference resource offers definitive information on the lexicon of the field. It includes almost 26,000 entries — approximately 1,000 more than the first edition — offering clear and authoritative definitions. It also offers balanced coverage of 90 subareas, with significantly revised and expanded content, especially in the areas of neuroscience, psychopharmacology, developmental psychology and many others. Thousands of incisive cross-references will deepen the user’s comprehension of related topics. It also includes more than 400 brief biographical entries on historical figures in psychology and other related areas.

Building Your Ideal Private Practice: A Guide for Therapists and Other Healing Professionals, Second Edition
By Lynn Grodzki, W.W. Norton & Co.

This second edition of a classic practice-building text covers essential how-to questions for those starting out in practice and points out the common pitfalls that new insurance-based or fee-for-service practices must avoid. For those already in practice and worried about profitability, it offers such informed strategies as the best way to create websites and other online marketing to find clients, then goes further to explain how to retain them. Other new chapters support veteran therapists edging toward retirement, including how to sell a therapy business for a profit, stay working solo or expand into a more lucrative group business model.

Creative Interventions for Troubled Children & Youth
Filled with creative assessment and treatment interventions to help clients identify feeling, learn coping strategies, enhance social skills, and elevate self-esteem. A wealth of practical tools.

50 Activities and Games for Kids With ADHD
Games, puzzles, activities and other resources to help children with ADHD. Gives real life examples & practical tips. For ages 8-13.

Bingo Games for Adults Set
Each set includes all of the materials needed for group play. Includes: Stress Bingo; Anger Bingo; Self-Esteem Bingo, and Healthy Relationship Bingo.

Six Thumball Set
Thumballs are a great way to build rapport. Useful 1 on 1 and in small groups.

We carry a large selection of counseling resources.

Get 10% off with code: Counseling Today
FREE Shipping on all orders over $99
* Continental USA only
Group effort
By Laurie Meyers
When a client seeks help, often the focused, tailored nature of individual counseling is exactly what he or she needs. But sometimes there is a particular alchemy in a group.

Many clients benefit from group counseling, either in addition to or instead of individual treatment. Why is that? The counselors to whom we spoke pointed to one element in particular: peer power.

Jonathan J. Orr, president of the Association for Specialists in Group Work (ASGW), a division of the American Counseling Association, thinks that group counseling is always a better alternative than individual counseling. "If you think about it," he says, "groups are the natural setting for us as humans. We are social beings by nature, interactive by nature, and group counseling most closely approximates how we live our lives."

From Orr’s perspective, it is the intense individual counseling setting — in which clients share everything with a single person — that is more artificial, demanding a kind of forced intimacy. People are not naturally inclined to reveal all of themselves to just one person, he contends. But in a group, clients can choose what to reveal and can also listen and learn from what others share. It also tends to be easier to discuss problems with people who have experienced similar difficulties, Orr concludes.

The groups described in the following pages focused on specific client populations that counselors determined would benefit most from the group process. These group leaders emphasize that although proper facilitation skills are crucial to the success of the group, many of the most important contributions — and changes — are the result of the participants’ interactions.

**Ex-offenders in need of job assistance**

When people are released from prison in North Carolina, they are offered services such as substance abuse counseling, help finding affordable housing and money management courses. But one type of service is not offered to these individuals trying to reintegrate into society — a service that ACA member Mark B. Scholl believes is absolutely essential: career development.

Scholl began offering group counseling in career development to ex-offenders this past fall. At the time, he was a counselor educator at East Carolina University in Greenville, and the impetus for forming the groups came from a graduate student who was also a probation officer. The student explained that ex-offenders were not receiving any career guidance and asked Scholl if he could work with them on career development and related career entry skills.

“It just seemed like such a glaring omission when you think about becoming reintegrated into society,” says Scholl, who is also a member of the National Career Development Association, a division of ACA. “What individuals need to feel like they are reintegrated … is a purpose, and work fulfills that purpose for many of us. One of the most important indicators of desistance” — or not repeating the criminal behavior — “is having employment.”

Given those circumstances, Scholl and his student set up a career program for ex-offenders in Beaufort County. The program, designed by Scholl, is promoted by the North Carolina Department of Public Safety, which oversees the state’s probation and parole officers. Scholl also sends fliers to local mental health agencies. The program is open to both men and women, and the length of the participants’ criminal histories varies, he says. Typically, group members have been convicted of substance-related offenses, such as possessing or selling drugs, or other nonviolent offenses. But a few applicants have convictions for weapons charges or other violent offenses. Although this will limit their employment choices, it does not disqualify them from joining...
the group, Scholl says. However, the group does require that participants be clean and sober, take any mandated psychotropic medications, speak and write English fluently and be either unemployed or underemployed.

Scholl set up a second program in Forsyth County after moving from East Carolina to Wake Forest University. He and his co-facilitators, all of whom do the work pro bono, work with one group of ex-offenders at a time in each program. The groups are small, typically having four to six members apiece. Depending on the group members’ progress, there are six to eight sessions, each of which lasts for two hours. The group meets every three to four weeks and spends one to two sessions on each of the four topic areas: assessment, résumé writing, interviewing skills and job search strategies.

The program starts with a skills assessment. Facilitators and group members work together to identify experiences that can be translated into viable job skills. Scholl and the facilitators emphasize that skills are anything a group member is good at and may even include abilities that the person used in his or her criminal activities.

“You might be really good with numbers, or you might be really good at selling things,” he explains to participants. “You might have been selling things that were against the law, like drugs or stolen merchandise, but you still have those transferable skills and … those are valuable.”

Everyone in the group gets a transferable skills list, Scholl says. “It is very comprehensive. It includes different categories of skills like communicating, influencing and organizing, and under each of those categories, there are about 20 transferable skills,” he explains. “Because they’re transferable skills, it doesn’t require formal training or education to have them or to claim them.”

For instance, “communication” can include skills such as being a good listener, being good at explaining things or giving directions, being good at persuading and selling or even, in certain contexts, arguing or debating, Scholl says.

Everyone in the group picks three skills and then shares them with the facilitators and group members. These transferable
skills will help the participants craft their résumés and also come into play as they learn about the interviewing process.

Scholl and the other facilitators give the group members sample résumés and a list of action verbs to use — for example, coordinate, sell, order, supervise, facilitate, interview — when writing their own résumé lines.

The group facilitators discourage ex-offenders from listing jobs that they held in prison on their résumés but stress that in addition to past paid work, participants can include volunteer work in churches and in the community. Skills that group members gained in prison or while engaged in criminal activity can be listed under the “professional skills” section of the résumé, Scholl says. The facilitators then edit and provide feedback on the group members’ résumés.

The next step in the group program is perhaps the most delicate and difficult: interviewing. Scholl describes the group’s counseling approach as postmodern, and that approach especially comes into play at this point.

“We emphasize that [they] are active meaning-makers,” he says. “Part of the postmodern tradition is that we all have that capacity to construct meaning for ourselves. So, for example, one thing we practice is self-disclosing your criminal record in a way that’s as positive as possible. You make the part where you talk about your mistake and your bad choice brief and concise, and you own that you are fully responsible. But you quickly move on to emphasizing that you’re not letting it [the mistake] define you as a person.”

Group members can then delineate the steps they have taken to improve themselves. By presenting their pasts in this way, they become the authors of their past experiences, Scholl explains.

Group members also prepare for interviews by constructing narratives around their strengths and what they can contribute to a company. Facilitators teach participants to use the acronym STAR (situation, task, action, result) to build these narratives, Scholl says.

For example, if wanting to demonstrate a strength such as sales or planning skills, the group member might tell a story about a time in high school when he or she was asked to sell magazine subscriptions door to door (situation and task) and made a plan to go to 10 houses each day after school for a week (action). As a result, the group member sold 35 magazine subscriptions and raised X number of dollars toward the purchase of uniforms for the high school band (result).

Another application of STAR could be a story about when the group member worked in a laundry setting (without emphasizing that it was the prison laundry) with a co-worker who wasn’t pulling his or her weight. The group member reasoned with the co-worker and, as a result, the team member’s work improved, Scholl says.

Group members write their STAR narratives and break up into pairs to role-play, taking turns being the interviewer and the interviewee, Scholl explains. They then give each other feedback on how to make their stories more compelling or clearer, asking questions such as “Why was this a strength?” or “What was the outcome?” Participants then reassemble to get feedback from the facilitators and other members of the group.
Scholl and his facilitators emphasize the importance of the STAR narratives to the group members. “We talk about … when you are interviewing for a job, things like your GPA or how much money you made in your last position, that’s not the kind of thing that makes you a memorable applicant,” Scholl says. “It’s the stories you tell. If 150 people apply [for a job], the one or ones with the most compelling stories are going to be unforgettable.”

The last stage of the group program involves job search strategies, which includes information about the importance of the informational interview, how to conduct an informational interview and how to approach someone for such an interview, Scholl says. But the strongest emphasis during this portion of the group is on self-presentation, including grooming and hygiene, he says. The facilitators also stress to group members the importance of being polite and friendly to everyone they encounter, because they never know when they might re-encounter someone in the job search, Scholl says.

Scholl acknowledges that he doesn’t possess much hard data on the overall efficacy of the group. But he says he can point to tangible products such as résumés — many group participants now have one for the first time. He and his facilitators also have anecdotal evidence, such as hearing that “Doug” got a job last week or “Mike” is going back to get his two-year degree so he can acquire the training necessary to work in a field in which he has a strong interest. Former group members also come back to sessions to share what they got out of the program.

“We recently had a woman come back to say that she was going to get her four-year degree,” Scholl recounts. Although the woman had been sober for several years prior to participating in the career group, she also credited the group with helping her maintain her sobriety.

For Scholl, this demonstrates why the value of group counseling goes beyond its curriculum or resources. The true value is in group members experiencing mutual support. “I think there is so much power in the ability to role-play with a peer and to view the group as an alliance of peers that can bring information, ideas and support,” he says.

When the caregivers need care

Laura Kestemberg is the director and associate dean of the newly established clinical mental health counseling master’s program at Molloy College in Rockville Centre, New York. For the past few years, she has been researching stress in parents of children with autism. Along with fellow ACA member Laura DeGennaro, Kestemberg joined Molloy’s initiative to launch an interdisciplinary autism center. As Kestemberg and DeGennaro, the clinical director and clinical coordinator, respectively, of the proposed autism center, worked with these children, they identified another group that needed help — the children’s parents. The social and behavioral impairments that accompany autism cause challenges that permeate almost every aspect of a family’s life, Kestemberg notes. “Parents [of children with autism] feel very isolated and ashamed and that it’s just them,” she explains. “Sometimes it’s been them [alone] battling with the school system or battling with providers.”

Parents of children with autism often experience a lack of social support, Kestemberg says. It’s not uncommon for friends and family members to pull away, and even if they don’t, it’s difficult for them to truly understand what the family is going through. But parents of other children with autism do understand, Kestemberg says, which makes a group counseling approach particularly helpful for them. In addition, group counseling has been shown to be very powerful for populations experiencing high levels of stress.

Both Kestemberg and DeGennaro had previously worked with parents of children with disabilities. “So we decided to put our heads together and try to have a clinical intervention for the parents,” Kestemberg says. They approached John Carpente, executive director of the proposed autism center and director of the Rebecca Center for Music Therapy at Molloy College, about providing this
As they were developing the group, Kestemberg and DeGennaro assumed they would run across other groups that focused on supporting the parents of children with autism, but that wasn’t the case. “We found that there were a lot of advocacy groups and a lot of parent training groups,” Kestemberg says. In training groups, counselors help parents learn to manage the child’s acting-out behaviors or show parents how to help the child manage in the school setting. “But it’s always about the child,” Kestemberg stresses. “We wanted … to do something where they could come to a group and [we could] say, ‘We’re going to talk about you — the parents, not your child. And we’re going to provide you with the strategies to help reduce your stressors.’”

Kestemberg and DeGennaro struggled with determining when to hold the group. They finally decided on the summer, when most children were still in summer camps, during the middle of the day. Evening groups were too difficult to coordinate because many of the parents didn’t have good child care options, and Kestemberg and DeGennaro didn’t yet possess the resources to offer child care while the group met.

Participants were recruited from the Rebecca Center and other local organizations that provide services to children with autism. Kestemberg and DeGennaro conducted a telephone intake interview with each parent. Although they wanted the group to include fathers, the mothers had greater availability. They ended up with a group of five women who met for 90-minute sessions 10 times throughout the summer of 2014.

Kestemberg and DeGennaro started each session by going around the circle and asking each woman to update the group on the most important things that had happened during the past week. At first, the women were more likely to bring up problems their children were having. “We tried to steer them toward what was going on with them or how what was going on with their child affected them,” Kestemberg says.

At first, it was difficult for some of the group members to open up. “The mindset was, ‘If I let a little bit out, I just won’t stop crying,’ or … ‘I’ll have so much anger that I’ll blow people away,’” Kestemberg recalls. Little by little, as Kestemberg and DeGennaro reassured the members that the group represented a safe place with others who were going through the same challenges, the women began to share. They talked about very painful topics, such as deciding whether to have another child, feeling alone in their marriages or yelling at their offspring and how ashamed they felt about doing that in the face of the child’s disability. “And other women in the group would say, ‘You know, I’ve done that too,’ or ‘I also think my marriage isn’t going so well,’” Kestemberg says.

As the women shared, an important concept became evident to each group member: “You are not alone.” In turn, this helped the group work toward the goals that Kestemberg and DeGennaro had set for the parents, which included:

- Feeling more empowered
- Decreasing their feelings of guilt
- Decreasing their stress levels
- Becoming more aware of their own needs
- Learning to use more positive coping strategies
The experiences the women shared weren’t just helpful emotionally but practically as well, Kestemberg says. For example, one mother expressed concern about going in front of a school district special education committee to talk about her child. These meetings involve educators, service providers and parents getting together to decide how best to meet the needs of the child. However, the gatherings can be emotionally charged because these parents often feel like it is a struggle to obtain the proper services for their children. Going in front of the committees, they feel the burden of having their facts straight and presenting a compelling case concerning why their requests for their children are valid.

In the case of this mother, the other group members suggested role-playing to help her prepare. Several of the other mothers had already gone through similar hearings, Kestemberg explains. Another common experience the women reported was feeling like they had to gird themselves before entering the house upon returning home. “A lot of our moms … said, ‘I’m so stressed that I can’t go right into my house. I sit in my car, have a cup of coffee, listen to the radio or do what I have to do before I have to face the chaos of what’s going on in the house,’” Kestemberg reports.

To help them cope with these overwhelming moments, DeGennaro and Kestemberg taught the mothers mindfulness techniques such as meditation, deep breathing, observing thoughts, mindful eating and walking, body scans and guided imagery. They also closed each session with a meditation or relaxation exercise and asked group members to practice the mindfulness techniques themselves as homework. Kestemberg and DeGennaro also informed the mothers about mobile apps for relaxation such as Stress Tracker, Breathe2Relax, MindShift and Take a Break! Guided Meditations for Stress Relief.

But so much of the benefit from the group came from what its members gave to each other, like offering to role-play, Kestemberg says. “[The group] was much more powerful than meeting with a therapist or mental health care provider one-on-one because they were with other moms who had gone through it,” she emphasizes. The group ended up being a mix of mothers with children who were very young and newly diagnosed with autism and mothers whose children were as old as 18. Kestemberg and DeGennaro initially thought it would be best to separate participants by age or level of severity of diagnosis, but because the total number of recruits ended up being so small, there was a need to combine them. This was a serendipitous necessity because it allowed the mothers with children who were newly diagnosed to see that there were other mothers who had “survived” and flourished throughout the school years.

These shared experiences resulted in a strong bond forming among the group members. The mothers would email each other between sessions to trade resources or just to offer support.

Kestemberg and DeGennaro conducted both pre-group and post-group parental stress assessments but did not find a significant decrease. However, they think that the mothers’ experience of opening up and actually acknowledging what they were going through may partly account for the results. Acknowledging the strain may have changed the way they reported their stress levels, DeGennaro explains.

This was only a pilot study, but DeGennaro and Kestemberg already have
Helping kids at risk of dropping out

How can schools help students who are struggling academically and at risk of falling behind or even dropping out? When ACA and ASGW member Jonathan Ohrt was an assistant professor in the counseling and higher education department at the University of North Texas (UNT) in the Dallas-Fort Worth area, he worked with groups of students to teach them skills that could help them succeed. UNT had an agreement with two area middle schools to work with students the schools deemed to be at risk for dropping out. Students qualified as at risk using a combination of teacher recommendations and items from the Texas Education Agency’s at-risk factors, which include not maintaining an average of 70 in two or more subjects in the previous or current school year and having multiple suspensions.

Ohrt and his team had researched which elements were most predictive of students’ academic success or failure. Although GPAs and test scores typically receive the lion’s share of attention, Ohrt found that social and emotional factors played larger roles. Armed with these findings, Ohrt decided to use the Student Success Skills (SSS) curriculum (designed by counselor educators, researchers and ACA members Greg Brigham and Linda Webb) because it has shown success with factors such as goal setting, self-regulation, academic self-efficacy and engagement. The curriculum also focuses on factors such as social skills, overall health and well-being, and physical activity. Although the curriculum features elements of psychoeducation, Ohrt believes the practical elements of goal setting and peer support are most crucial to group members’ success.

Ohrt and his co-facilitators led three different groups, each containing six to eight students, at the two middle schools. The groups ran for eight weeks with one 40-minute session per week.

The first session was spent on introductions, with the students getting to know one another and the facilitators. The second session was psychoeducational in nature, with the leaders talking about the life skills that are related to being successful, such as goal setting, progress monitoring, memory skills, managing attention and managing anger. The SSS curriculum includes worksheets that explain the life skills areas, and the facilitators went over these with the students to help them identify areas they needed to work on.

After that, the students set goals and worked on maintaining them, which provided the focus for sessions three through seven. The group leaders helped the students visualize setting and achieving goals. “Talk to the students about what their goal might look like and what the concrete steps are,” Ohrt advises. “As a group leader, you need to be able to visualize what would help them succeed [and] what is going on that is causing them not to succeed.”

Ohrt likes to use solution-focused counseling during this process, prompting group members with questions such as, “Did you have a time when you were doing well in school? What was going well? What changed?” He adds, however, that implementing solution-focused counseling isn’t a requirement for leading such a group. Counselors can use their preferred theoretical orientation to help group members visualize their goals.

Generally, Ohrt says, each group member chooses just one goal on which to focus because making small, specific adjustments over time tends to be the most sustainable path to success. Typical goals include:

- I’m going to complete my homework on time more often
- I’m going to spend X number of hours preparing for my math tests
- I’m going to focus on paying more attention in class
- I’m going to work on controlling my anger

The students paired off at the beginning of each session and talked about the progress they had made with their goals. Then the entire group convened again, with each student again sharing his or her progress. If certain group members were having difficulties with their particular goals, the other students often shared what had worked — or what hadn’t worked — for them. If no one offered a possible solution, Ohrt or the other facilitators spurred discussion by asking questions such as “Has anyone struggled with that?” or “Have any of you heard something else that another student did that you might want to try?”

Session eight, the final session, served as a general wrapup of the group, with students talking about what they had learned and how they had progressed.

Ohrt and his team tested for three elements both before and after the groups: self-regulation, perceived academic efficacy and self-esteem. The results showed that although the students’ self-esteem had not improved, they had made strides in both their self-efficacy and self-regulation. When the team repeated the testing two months after the groups concluded, however, it found that the students had gone backward a bit on their improvements. Ohrt thinks that holding brief booster sessions every few months after a group ends might help to maintain the students’ gains.

Ohrt is now working as an assistant professor of educational studies at the University of South Carolina, where he is supervising graduate students leading similar groups in several area schools.

To contact the individuals interviewed for this article, email:

- Jonathan J. Orr at jorr@gsu.edu
- Mark Scholl at schollmb@ufiu.edu
- Laura Kestemberg at lkestemberg@molloy.edu
- Laura DeGennaro at ldegennaro@molloy.edu
- Jonathan Ohrt at jonathanohrt@yahoo.com

Laurie Meyers is the senior writer for Counseling Today. Contact her at lmeyers@counseling.org.

Letters to the editor: ct@counseling.org
No laughing matter?

By Kathleen Smith
Counseling is serious business, but there is also something to be said for skillfully using humor as a therapeutic tool with clients, students and ourselves.

A client comes in for his first counseling session. He has a carrot sticking up his nose and a banana in his left ear.

“Help!” the client cries. “Can you tell me what’s wrong with me?”

“Simple,” the counselor says calmly. “You’re not eating properly.”

Laughter is an essential part of the human experience, so it’s no coincidence that a profession that tries to make sense of the complexity and absurdity of human nature occasionally finds itself the butt of a joke or the punch line of a comic strip. In its ongoing quest to be “taken seriously,” however, the counseling profession seemingly sometimes forgets that humor can be a key component of wellness and even the therapeutic relationship.

The profession’s squeamishness with jokes arguably can be traced back to the image problem that psychotherapy has in the media, with TV show counselors often portrayed as zany bohemian personalities in offices full of waterfalls and wind chimes. If Tracey Ullman as Ally McBeal’s karaoke-singing shrink and Lisa Kudrow on her Web Therapy comedy series have served as our ambassadors to the world, then no wonder we’re so nervous.

Despite what television portrays, it’s no secret that counseling is serious business. Clients wouldn’t come to counselors searching for solutions if their problems were just everyday troubles that could be fixed with a pat on the back or a funny movie. An equally sobering reality is counselors’ duty to avoid doing harm to clients, which is infused in the profession’s ethics code. Counselor educators spend so much time drilling the principle of nonmaleficence into the heads of graduate students that there hardly seems space left for a crash course in comedy.

But the reality is that we live in a world that sometimes borders on the absurd. And when things don’t work out exactly like they’re supposed to, we can either run for cover or we can laugh about it. “Or, as Taylor Swift might say, ‘Shake it off,’” jokes Samuel Gladding, professor of counseling at Wake Forest University and a past president of the American Counseling Association. “Humor helps us shake things off. Anxiety decreases when we realize that we’re not perfect and that we don’t have to be. Humor gives us that right to laugh. It helps us see more of our humanity and realize that the world isn’t always a somber, serious place.”

Despite sometimes being shunned, the therapeutic use of humor is not a new idea in counseling, and its lengthy history in psychology ranges from the wacky to the profound. Sigmund Freud saw humor as a means of expressing thoughts in the unconscious that had been suppressed in society. Viktor Frankl afforded the hope that humor was a means to lift the human experience above even the most horrible suffering.

Of course, no character in the annals of therapeutic humor is as unforgettable as Albert Ellis. A firm believer that taking oneself too seriously was a sign of psychopathology, Ellis took his in-your-face techniques to an unprecedented level. His infamous “rational humorous songs” were meant to illuminate the absurdities of irrational thinking, even though their bawdy lyrics might make most counseling professionals cringe today. We can no more imagine an addictions counselor leading a recovery group in a rousing chorus of “Drinking Is The Thing for Me!” (sung to the tune of “Yankee Doodle”) than we can picture anyone getting away with these tactics other than, well, Ellis himself.
By its very definition, humor is a lighthearted topic, but in the past few decades, science has taught us to consider its benefits a little more sincerely. “Humor is one of the handmaidens of wellness,” says Gladding, a frequent presenter on the subject. “The endorphins kick in, the heart rate is better and our breathing is deeper. There’s an old saying that those who laugh, last.”

Science also tells us there are health benefits to laughing or smiling even when we don’t feel like it. Take, for example, a 2012 study at the University of Kansas, where psychologists Tara Kraft and Sarah Pressman tested whether there is any truth to the phrase “grin and bear it.” Before completing short stress-inducing tasks, participants in the study were instructed to smile, to hold their face in a neutral expression or to hold chopsticks in their mouth to simulate a forced smile. Kraft and Pressman found that those who smiled or held chopsticks in their mouths experienced lower recovery heart rates compared with those who maintained neutral expressions. So, although it might sound odd, there seems to be some evidence that people who force themselves to smile in tough situations are healthier and probably happier.

“Before we even knew about the physical effects, Gordon Allport taught us that humor is a characteristic of healthy people,” Gladding says. “It helps with self-awareness, insight and tolerance, yet somehow we conceptualize counseling as serious and without those lighter moments.”

Although the potential benefits are obvious, using humor in counseling is often easier said than done. Sometimes it takes more than a TV show or a New Yorker cartoon for humor to jump-start these effects. Thus, counselors inherit the challenge of determining whether their own funny insights can flip the switch for clients and lighten their perspective.

Terry Bordan, a professor of counseling at Long Island University and a member of ACA, recalls how she once worked with a client who blamed herself for all of her family’s problems. In the client’s mind, she was at fault for everything. So, Bordan turned to her and said, “But what about the economy?” The client seemed bewildered by this response, so Bordan replied, “Everything is your fault, and the economy is tanking. Surely you must have something to do with that.”

The client immediately began laughing, realizing the absurdity of her thinking. “Laughter is a way of celebrating and therapeutically engaging the absurdities of life,” Bordan says.

This type of humor, known as a paradoxical response, is a commonly used technique in counseling. For it to be effective, however, clinicians must first ensure that they have established good rapport with the client. Bordan notes that if a client doesn’t laugh, the intervention will backfire, leaving the person confused or disheartened.

Gladding affirms this judiciousness, noting that respect for the client should be valued above all. “But sometimes,” he says, “I’ll use it with somebody who just refuses to speak, like a teenager. I might say, ‘Wow, this is really bad because now you’re going to have to always order pizza online. You can’t call in.’ Just something like that.”

**Teaching humor**

If humor could play such a potent role in the therapeutic relationship, why don’t graduate counseling programs or organizations that offer continuing education dedicate more time to addressing the topic? To begin, educators are not quite sure whether humor is a skill that can actually be taught.

“I don’t know if you can teach somebody to have a sense of humor,” Bordan says. “A counselor has to be their authentic self, and if humor isn’t part of your DNA, then you’re not going to be able to use it successfully. If there’s a spark, you can get more of a flame. But zero times a million still equals zero.”

Gladding suggests that counselor educators and supervisors can focus their energies on helping counselors become better at telling anecdotes or assembling a few jokes to use at appropriate times. But counselors should never feel pressured to be funny, he adds. “Just like some people are better athletes than others, some people are better at seeing the lighter, brighter side of life in a humorous way,” he says.

As for the graduate classroom, Bordan believes there is absolutely a place for humor. She says one of the nicest things a counseling student ever told her was that taking a class with her was like...
JCD Article: ACA 265, Counseling Considerations for the Twice-Exceptional Client

Learning Objectives: Reading this article will help you:
1) Examine how to identify and treat twice-exceptional clients.
2) Explore successful interventions counselors have used when working with twice-exceptional clients.

Continuing Education Examination

1) A twice-exceptional client is an individual who possesses strengths in one or more talent domains as well as:
   a) Developmental disability
   b) Giftedness
   c) A diagnosed disability or mental health disorder
   d) A substance use disorder

3) Which of the following is not a common issue encountered by twice-exceptional clients?
   a) Bullying and peer-related concerns
   b) Oppositional and behavior-related concerns
   c) Social and emotional concerns
   d) Career counseling and college transition concerns

4) If a twice-exceptional student does not report social or emotional difficulties, then these issues do not need to be addressed in counseling.
   ____ True     ____ False

5) Successful identification of and intervention with twice-exceptional students focuses on diagnosis, remediation and the selection of appropriate:
   a) Peer groups
   b) Psychoeducation geared toward twice-exceptional students
   c) Talent domains and programming
   d) Teachers

I certify that I have completed this test without receiving any help. Signature ______________________________ __________ Date

Rate the following:

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>No opinion</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

____ I learned something I can apply in my current work
____ The information was well presented
____ Fulfillment of stated Learning Objectives was met
____ This offering met my expectations

Profession:
____ Alcoholism & Drug Abuse Counselor
____ Counselor
____ Counselor Educator
____ Psychologist
____ Social Worker
____ Student
____ Other

Instructions

Online: Save $3.00 by purchasing and completing the JCD test online at www.prolibraries.com/counseling.
Mail: (1) Download the article for free at www.prolibraries.com/counseling, Click “JCD articles” under “Resources” to locate and download the article. (2) Complete the test and mail (with payment made to American Counseling Association) to: ACA Accounting Department/CT, American Counseling Association, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22340.
Your CE certificate will be emailed, unless noted otherwise, in 2-3 weeks. Questions? 800-347-6647, x306

Please print clearly
Name: __________________________________________________________
ACA Member Number: _____________________________________________
Zip Code: ______________________________________________________
Phone: _________________________________________________________
Email: _________________________________________________________

Total amount enclosed or to be charged  ____ $25.00 member     ____ $35.00 nonmember
   ____ Check/money order (payable to ACA in U.S. funds)
   ____ VISA   ____ MasterCard   ____ American Express   ____ Discover
Card #: ______________________________
CVC Code:   __  __  __  __ Exp. Date: ____________________________
(AmEx, 4 digits above card number; VISA, MC, Dis., 3 digits by signature line)
Cardholder’s Name: _____________________________________________
Authorized Signature: _________________________________________

June 2015 | Counseling Today | 41
taking a class with Joan Rivers. “People take themselves too seriously, including researchers and educators. And humor is inherently not serious. So it’s almost a frivolous topic, and perhaps it’s shied away from in scholarship and in the classroom because of that,” Bordan says.

Eugene Goldin, a professor of counseling at Long Island University and co-author of an upcoming humor book with Bordan, advises that counselors must find a balance between using humor as a teaching tool and underscoring the seriousness of the work. “We don’t want to leave students with the impression that a client comes in and you start telling jokes right away,” Goldin says. “We downplay humor like we downplay self-disclosure as a counseling intervention when we’re teaching our students, because we don’t want the session to become all about them.”

As with any therapeutic technique, a host of multicultural concerns and considerations accompany the use of humor with clients. Humor is framed by culture and worldview, Goldin says, and it can do more harm than good if a client reacts with confusion or is deeply offended.

“Look at the climate right now,” Bordan adds. “What some people view as humor, others view as a call to war. You have to be so terribly careful and not become involved with something that might be viewed as irreverent.”

Research has found that when working with diverse populations, the counselor’s use of humor can help clients to perceive the counselor as their ally in the strange or potentially threatening environment of the consulting room. In a 2006 article in the Journal of Counseling & Development examining humor in counseling with African American college students, Linwood Vereen and his co-authors proposed that humor could help clients develop a sense of self-efficacy. They suggested that by allowing the counselor and client to process difficult subjects and challenges, humor could be a redemptive feature that promotes optimism and empowerment among diverse clients. They also warned, however, that a counselor’s use of humor could be insensitive and even harmful if it devalued a client’s concerns and experiences.

A double-edged sword
Therapeutic work can also benefit when counselors choose to incorporate humor into their own lives. After all, it can be difficult to see the lighter side of life when you meet with multiple clients each day who struggle with depression or self-doubt.

“Counseling is toxic in so many ways,” Gladding says. “It’s not that we invite toxicity into our lives, but listening to clients can kind of wear you down.” He notes that he will sometimes attend a comedy act or see a funny movie just to laugh, because it helps him feel more resilient.

Gladding also acknowledges that humor can help prevent counselors from taking themselves too seriously when they make a mistake. He shares the story of how a misunderstanding turned from daunting to funny in his own practice.

“Once I was working with a person of color, and she kept saying, ‘I really despise WASPs.’ I’m an Anglo-Saxon-looking guy, and I kept thinking, ‘Oh my goodness.’ What I didn’t realize was that behind the curtains, there were a number of wasps in the room. Then I [finally] realized she wasn’t talking about me at all. And I just had to laugh at myself and tell her I finally understood what she was saying.”

But there can also be a dark side to humor in the counseling room, particularly if clinicians make jokes when they feel uncomfortable or resort to sarcasm if they’re in a bad mood. Through supervision and self-reflection, counselors should examine when and how they try to be funny. If they’re using sarcasm or dark or risqué humor, then it’s probably not for the betterment of their clients.

“Humor is a double-edge sword,” Gladding warns. “It can hurt or it can heal. If I’m taking inventory of the types of humor that I’m using and I’m finding that I’m putting people down or distracting from what we’re trying to accomplish, then I need to do something else. I need to ask myself whether it’s about [my] self-enhancement or the client’s self-enhancement.”

Incorporating a therapeutic use of humor into counseling practice is about taking small steps. Clinicians shouldn’t feel like they’re trying out for Saturday Night Live or altering their personalities to try to be funny. After all, the therapeutic use of self, including humor, is all about being authentic. The counselors interviewed for this article recommend the following strategies that clinicians and their clients can use to tap into humor as a wellness practice.

Assign humor homework. Gladding shares that he has assigned homework that involves laughter to his clients. “I ask them what they’d like to read or watch — maybe a favorite author or a comedian,” he says. If the client can’t think of anything, Gladding recommends funny but innocuous classic comedies featuring the Marx Brothers or the Keystone Cops.
**Schedule time to be silly.** Bordan says we should all — meaning counselors and clients — take time out of the day to laugh. “Just do something foolish and silly, whether it’s watching something funny on television or playing with a pet,” she says. “Or maybe just force yourself to laugh. Laughter is contagious, and we benefit when we dedicate part of our day to the practice.”

**Use humor as a diagnostic tool.** Assessing the role of humor in a client’s life can be an incredibly meaningful tool for counselors, Bordan advises. “Even if that client has no sense of humor, it is a diagnostic clue that can be used in assessing what is going on with [that person],” she says. If a client tends to use sarcasm or cynicism as a self-protective mechanism, then the counselor might be wise to avoid using humor as a tool with that particular client.

**Use humor to change perspective.** In a 2006 article co-authored with Goldin, Bordan and Gladding, Daniel Araoz recommended having clients see their life through the eyes of a cartoonist. This approach is meant not to devalue a client’s experiences but rather to increase awareness. “To uncover another level of reality in what happens around us is a special characteristic of a large part of what’s humorous and has a unique poetic quality,” Araoz wrote. “It may also be a demonstration of a very wise attitude: to see below the surface, to make the unconscious conscious.”

**Mark teaching points with laughter.** For counselor educators, humor can hammer down important points in the lesson. “Whenever we hear certain songs,” Gladding says, “we remember certain events that were happening in our lives at the time. When we punctuate a lesson with humor, the same process occurs. We make a mark where students can remember.”

**Seek feedback.** If a counselor wants to experiment with humor, it’s important to take baby steps. “Get feedback from clients and from supervisors about your own particular therapeutic use of self,” Goldin recommends. He emphasizes that counselors should never force techniques involving humor if they don’t come naturally. “The use of humor is about the client,” Bordan adds. “You’re not in a comedy club waiting for applause.”

When asked, Gladding admitted to feeling pressure to be funny when he presents on the topic of humor at professional counseling conferences. But he finds that starting off with a joke is great way to grab the attention of the audience. Here’s one he shared with me:

What did the math book say to the counseling book?

“Oh, man, I’ve got problems.”

So what did the counseling book say to the math book?

“It’s OK. I’m solution-focused.”

Kathleen Smith is a licensed professional counselor and writer in Washington, D.C. Contact her at ak_smith@gwmail.gwu.edu.

Letters to the editor: ct@counseling.org
Incorporating feedback-informed treatment into counseling practice

Knowledge Share – By Sidney Shaw & Kirsten Murray
How do you determine your level of effectiveness in your work with clients? In everyday practice, counselors typically rely on clinical judgment and their own assumptions about the therapeutic alliance and client progress. Few would argue against the importance of good clinical judgment, but there is persistent evidence that counselors’ views of the alliance and client outcomes are often at odds with the views of clients.

In regard to helping clients attain positive outcomes, research evidence and clinical wisdom converge strongly on the therapeutic alliance. However, while research and meta-analyses have repeatedly demonstrated the power of the alliance, an important nuance in those findings is that the client’s view of the alliance is consistently found to be a better predictor of counseling outcome than is the counselor’s view. Additionally, counselor views of the alliance frequently do not correlate well with the views of the client.

Because client perceptions of the alliance are a better predictor of outcome than the counselor perceptions are, a validated model for collecting continuous feedback from the client is needed. Furthermore, integrating client feedback into counseling services can help counselors check their assumptions, increase counseling’s effectiveness and privilege the client’s voice. This article is a review of a systematic, validated and practitioner-friendly method for monitoring the client’s view of the alliance and outcome known as feedback-informed treatment (FIT).

**Formal client feedback**

Collecting feedback from the client emphasizes counseling tenets related to understanding clients’ subjective experiences, cultivating a quality relationship, supporting clients’ abilities to choose their goals and how to meet them, and working in service of a positive outcome for clients. In counseling practice, counselors typically evaluate these important factors informally, but this is an area in which counselors — and clients — can benefit from formal feedback. Indeed, numerous studies have found that counselors, despite their confidence that they accurately appraise the strength of the alliance and client progress, are poor at gauging these elements when using clinical judgment alone.

In a representative study from 2009, researchers Morten Anker, Barry Duncan and Jacqueline Sparks conducted a randomized clinical trial of couples counseling in a naturalistic setting. Clients were randomly assigned to either a feedback group (in which the counselor would obtain session-by-session feedback from clients using a brief alliance measure and an outcome measure) or to a “treatment as usual” group. Pre-study surveys showed that all the counselors believed they were already acquiring outcome and alliance feedback from their clients without the use of a formal feedback process and that formal feedback would not improve their effectiveness. In contrast...
The American Counseling Association (ACA) is interested in reviewing proposals for books on counseling and human development. ACA publishes books written for professional counselors, clinicians, counselor educators, and counselors-in-training.

This year, the ACA Publications Committee reviewed the current ACA book catalog and competing markets to identify gaps in our current literature in an effort to meet the needs of clinicians, educators, students, and researchers. In the past, authors interested in writing a book downloaded the author guidelines and submitted a proposal. ACA still plans to keep this same process, however, our hope is that each year the ACA Publications Committee will identify gaps in the current ACA literature, inform members of these gaps, and then make a call for additional book proposals based on these topical areas.

After reviewing the current ACA catalog and competing markets and working with the ACA Governing Council, the following gaps were identified:

1. Neuroscience
2. Wellness
3. Crisis and trauma
4. Basic CBT book

We encourage authors to submit book proposals on the topics listed above.

Potential book authors can locate the ACA Guidelines for Proposal Submission at https://www.counseling.org/publications/book-proposals. Information regarding the proposal components, review process and procedures, and manuscript writing style are outlined in detail.

For questions and proposal submissions, please contact:

Carolyn C. Baker
Associate Publisher
cbaker@counseling.org
800-347-6647 x356
703-823-9800 x356

to those pre-study beliefs, findings revealed that 90 percent of the counselors improved their outcomes with clients after integrating formal client feedback using brief measures of alliance and outcome. This finding, coupled with findings from similar studies, illustrates the tendency for counselors to assume that their informal method of checking in with clients is as useful as a formal feedback process.

Because of cumulative research on the client’s view of alliance as a predictor of outcome, research on formal client feedback has burgeoned during the past decade, and the evidence is compelling. In 2010, outcome researcher Scott Miller conducted a review of existing research on integrating client alliance and outcome feedback into counseling services. At that time, 13 randomized trials with more than 12,000 ethnically and diagnostically diverse clients had found that simply incorporating client feedback improved counseling outcomes by as much as 65 percent, decreased client dropout rates by half and decreased deterioration (clients who got worse) by 33 percent. The act of consistently engaging with clients about their experience of the alliance and the degree to which the sessions were helpful had a profound influence on client outcome.

**Barriers to formal feedback**

The term "formal" in this case refers to using validated tools for eliciting client feedback about their perception of the alliance and outcome. We acknowledge that the notion of using a form to obtain client feedback can create resistance among counselors. The method might sound reductionistic to some clinicians, or they might regard it as having the potential to trivialize the alliance by assigning a number value to it.

Although these concerns are understandable, it is important to remember that client feedback tools are not for assessment in the traditional sense. Rather, they are primarily dialogue tools. The aim is to open dialogue and put clients in the driver’s seat to express their experience of the alliance and whether progress is being made. This in turn enables the counselor and client to work collaboratively to make adjustments and individualize the services being delivered.
When we present this information at conferences, there are sometimes counselors who indicate that they check in with their clients verbally or informally about the alliance and outcome. Counselor intentions to check in with clients are no doubt rooted in an aim to truly understand clients’ experiences. Some research has indicated, however, that counselors think they check in with clients far more frequently and consistently than they actually do. Indeed, our own experience of first beginning to use an alliance measure was that sometimes we would give the measure at the end of the session and sometimes we wouldn’t. The problem with counselors choosing whether or not to check in formally about the alliance is that it places the decision in the wrong hands.

**FIT alliance and outcome tools**

FIT involves incorporating the client’s perspective about the therapeutic alliance and outcome. Specifically, FIT includes the use of two ultra-brief, validated measures that are used to open and broaden conversation about the alliance and outcome.

Some research has indicated that counselors think they check in with clients far more frequently and consistently than they actually do.

The Session Rating Scale (SRS) is a four-item measure of the therapeutic alliance that the counselor administers at the end of each session. This takes only about one minute to do. The first three items of the SRS correspond directly with the domains of the alliance found in the dominant definition in the mental health field. The fourth item simply asks how the client felt about the session overall.

The four items of the SRS are as follows:

1. **Relationship** (degree to which the client felt heard, understood and respected)
2. **The goals and topics** (degree to which the client was able to focus on what he or she wanted to in session)
3. **The approach or method** (how the client felt about the counselor’s approach)
4. **Overall** (degree to which the overall session felt right and on track for the client)

Each of the items is on a 10-point visual analog scale. Clients are asked to reflect on the session, complete the brief form and then discuss their feedback with the counselor.

The Outcome Rating Scale (ORS) is a brief four-item tool for measuring the client’s perspective of change or improvement (or lack of improvement) in relation to the initial score at intake. The counselor administers the ORS at the beginning of each session. This takes about one minute. The first three items are based on three domains of the much longer Outcome Questionnaire-45, while the last item refers to the client’s general...
Written as an introduction to the field of addiction counseling, this text covers the fundamental knowledge, understanding, and skills necessary to counsel people who are struggling with addiction. Drs. Brooks and McHenry provide a straightforward, compassionate, and holistic approach to treatment and recovery, from the major theoretical underpinnings, to assessment and diagnosis, to relapse prevention and spirituality. With a focus on current clinical applications and how-tos, this book is ideal both for master’s-level addictions courses and mental health clinicians.

Topics addressed include cultural and gender issues, including work with LGBT clients; drug classifications and referral; assessment, diagnosis, and interview techniques; the continuum from nonuse to addiction; work in college/university, school, and community/mental health agency settings; developmental approaches in treatment; the role of the family; grief and loss in addiction; group counseling; relapse and recovery; spirituality and support groups; addictions training, certification, and ethics; and the importance of counselor self-care. Exploration questions and suggested activities are presented in each chapter.

List Price: $68.95 | **ACA Member Price: $49.95**

Shipping and Handling: $8.75 ($1.00 for each additional book)

Order Online: counseling.org/bookstore
By Phone: 800-422-2648 x222
(M-F 8am – 6pm)

---

**Introducing formal feedback in counseling sessions**

With most any intervention, process or method in counseling, simply going through the motions doesn’t translate into effective, competent practice. The same applies to the use of the ORS and SRS. These tools are intended to privilege the client’s voice and provide a reference point for the client’s experience. Intention, openness to feedback and clarity of purpose are required of counselors to truly engage clients collaboratively. With this in mind, sample scripts for introducing the measures are provided below. Keep in mind that the ORS is administered at the beginning of each session and the SRS at the end of each session.

**Introducing the ORS**

“A primary focus of mine in working with you is to make sure that you are getting what you want and need out of our sessions. So, it is really important that we are discussing and tracking how you are doing and whether things are improving in your life. I have a really brief form that I use every session just to get a snapshot of how things are going. This form allows us to get a sense of important areas of your life and how things are changing or not changing over time. It also helps me to figure out if I am being helpful or not, and that is really important for me to know. It will only take a minute or so to complete. On each of these four scales, just place a hash mark indicating how things have been for you over the past week, with lower scores to the left and higher scores to the right.”

---

*NEW EDITION!*  
A Contemporary Approach to Substance Use Disorders and Addiction Counseling  
Second Edition  
Ford Brooks and Bill McHenry

“This edition of A Contemporary Approach to Substance Use Disorders and Addiction Counseling is superior. It is clearly written, easy to understand, and the topical areas covered provide useful and highly relevant information for both beginning and experienced counselors. It expands the authors’ original work and is one of the most creative, addictions-specific books for counselors available.”

—Gerald A. Juhnke, EdD  
Professor/American Counseling Association Fellow  
The University of Texas at San Antonio

---

Introducing formal feedback in counseling sessions

With most any intervention, process or method in counseling, simply going through the motions doesn’t translate into effective, competent practice. The same applies to the use of the ORS and SRS. These tools are intended to privilege the client’s voice and provide a reference point for the client’s experience. Intention, openness to feedback and clarity of purpose are required of counselors to truly engage clients collaboratively. With this in mind, sample scripts for introducing the measures are provided below. Keep in mind that the ORS is administered at the beginning of each session and the SRS at the end of each session.

Introducing the ORS

“A primary focus of mine in working with you is to make sure that you are getting what you want and need out of our sessions. So, it is really important that we are discussing and tracking how you are doing and whether things are improving in your life. I have a really brief form that I use every session just to get a snapshot of how things are going. This form allows us to get a sense of important areas of your life and how things are changing or not changing over time. It also helps me to figure out if I am being helpful or not, and that is really important for me to know. It will only take a minute or so to complete. On each of these four scales, just place a hash mark indicating how things have been for you over the past week, with lower scores to the left and higher scores to the right.”
The client then completes the ORS and, afterward, the counselor attends to and mentions any particular domain that is lower than the rest. The session then progresses in a traditional counseling format.

**Introducing the SRS**

“Before we wrap up today, I would like to ask you to fill out another really short form. This one deals directly with how our session was today. It is really important to me that you are getting what you want and need from coming here, and how well we work together directly relates to how well things go for you overall in counseling. I truly want to hear any feedback you have about our session, especially if it is feedback that you might think is not positive or about something that was lacking in our session. Sometimes it may be something big that I missed or that wasn’t right in our session, and I want to hear about that. However, it could also be something seemingly small that wasn’t quite right about our session today. It may seem so small that it’s not worth mentioning, but I’d like it if you would mention it. I also want to emphasize that you don’t have to be concerned about hurting my feelings and that I really welcome your feedback. Like with the other form, there are four different scales, with lower scores to the left and higher scores to the right. Just put a hash mark on each line indicating how the session was for you today. Thanks!”

After the client completes the SRS, the counselor inquires about and attends to scores in any domains that are lower. The counselor needs to maintain a stance that communicates not just openness to feedback but also that the counselor will attempt to incorporate the client’s feedback to guide treatment.

**Creating a culture of feedback**

On the surface, the use of these brief measures may seem simple. In fact, this is often the initial response of counselors when they begin using the SRS and ORS. However, it quickly becomes apparent that these tools can be used in a manner that makes them little more than a meaningless ritual at the beginning and end of sessions. To use these tools in a way that yields truly beneficial results for clients, counselors need to create a culture of feedback.

The first, and perhaps most challenging, step in this process is for...
New!

International Counseling Case Studies Handbook
edited by Roy Moodley, Marguerite Lengyell, Rosa Wu, and Uwe P. Gielen

“This book offers a detailed account of how clinicians from around the world conceptualize their cases and employ a host of diverse counseling strategies. Through reading this book, practitioners, researchers, and trainers in every setting will acquire new insight and skills in the universal and unique aspects of the counseling process.”
—Lawrence H. Gerstein, PhD
George & Frances Ball Distinguished Professor of Psychology-Counseling
Ball State University

“This is a wonderful collection of engaging therapeutic stories that illustrate the complexities of counseling within different cultural contexts. It is an excellent stimulus to broaden both students’ and scholars’ conceptualization of counseling and psychotherapy.”
—Puncky Paul Heppner, PhD
University of Missouri

In this book, authors from 33 countries demonstrate multicultural skills and competencies through case studies that illustrate approaches to counseling and psychotherapy in their countries. Following an introductory section on the use of case studies, chapters focus on a cross section of countries in Africa; Australia and Asia; Central, North, and South America; Europe; and the Middle East. Each case includes the client’s presenting concerns, a culture-sensitive assessment and treatment plan, an analysis and critical reflection of the case, and questions for discussion. The final chapter presents a comparative analysis of the cases.

2015 | 336 pgs | Order #78111 | ISBN 978-1-55620-335-0
List Price: $58.95 | ACA Member Price: $42.95

Order Online: counseling.org/bookstore
By Phone: 800-422-2648 x222
(M-F 8 a.m.–6 p.m.)

American Counseling Association

---

counselors to become very clear about whether they really want client feedback and if they are prepared to handle feedback with openness and receptivity. In essence, the counselor’s goal with the SRS is to strive hard to encourage clients to share even small things that were not to their satisfaction about the session. Indeed, research findings on top-performing counselors (that is, counselors whose outcomes are significantly greater than those of the average counselor) indicate that they typically receive lower SRS scores in the early stages of treatment. These counselors are very adept at getting clients to share feedback about elements of the alliance that are weak. In fact, when counselors receive consistently high SRS scores from clients, it is often an indication that they have not adequately created a climate in which clients feel comfortable providing truthful feedback.

Creating a culture of feedback with clients essentially means that counselors are very receptive to feedback and will use this feedback to guide and adapt services. Soliciting feedback effectively requires that counselors clearly explain the ORS and the SRS as well as the purpose of these two tools. When counselors communicate openness to feedback (especially critical feedback) and responsiveness to client preferences, they are more likely to receive the feedback they need to individualize services.

Summary recommendations

There is strong evidence that integrating alliance and outcome feedback into counseling improves overall outcomes. FIT is pan-theoretical and can be used in conjunction with any treatment approach. Key considerations to start integrating client feedback into counseling services are as follows:

- Download the ORS and the SRS from the International Center for Clinical Excellence at centerforclinicalexcellence.com. This is free for individual practitioners.
- When downloading the performance metrics, read the information on how to score and introduce the measures.
- Practice administering the measures with a colleague. Use your own language, but hit the key points highlighted in the sample introductions in this article.
- Seek internal clarity on your openness to hearing and responding
effectively to client feedback. Remember that a characteristic of top-performing counselors is that they often solicit negative alliance feedback (and receive it nondefensively) and are able to modify treatment according to that feedback.

- Read additional articles on this topic, a number of which can be accessed on Scott Miller’s website (scottdmiller.com).
- Work to create a culture of feedback with clients. Don’t use the ORS or the SRS with existing clients, but begin to use the measures in every session with new clients.
- Track client ORS scores on a graph for visual indication of the client’s outcome over time.
- If clients are not improving (by an increase of five points from the initial intake score) on the ORS by session four, have a conversation with the client about the alliance and what could be done to improve treatment.
- Seek supervision or consultation from someone who is familiar with FIT.
- Keep in mind that even the best counselors have clients on their caseloads who are not progressing or improving. Having a reference point for clients’ experiences of change allows you to individualize services and improve client outcomes.

**Conclusion**

As counselors, we have been trained to build and invest in an alliance with our clients. The therapeutic factor of the alliance itself has been found to be a better predictor of client outcomes than client diagnosis, the professional discipline of the clinician, years of clinician experience, the client’s previous treatment history and the specific treatment approach. Attending to the therapeutic alliance is critical for successful counseling, and given that counselors’ and clients’ views of the alliance are often at odds, a method for aligning those perspectives is needed. Integrating FIT practices is a way to create a consistent culture of feedback, privilege the client’s voice and individualize treatment needs for the people we serve.

Those interested in more information on this topic can refer to Sidney Shaw and Kirsten Murray’s article, “Monitoring alliance and outcome with client feedback measures,” published in the January 2014 issue of the *Journal of Mental Health Counseling.*

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

Sidney Shaw is a core faculty member in the clinical mental health counseling program at Walden University and a certified trainer for the International Center for Clinical Excellence. Contact him at sidney.shaw@waldenu.edu.

Kirsten Murray is an associate professor and chair of the Department of Counselor Education at the University of Montana. Contact her at kirsten.murray@umontana.edu.

Letters to the editor: ct@counseling.org

---

**PH.D. DEGREE**

**Pastoral Counseling**

**New Weekend Format**

- Combines spiritual perspectives with clinical counseling and psychotherapy
- Meets 5-6 weekends per semester (Friday evenings and Saturdays)
- Provides opportunities for clinical hours toward licensure
- Equips scholars and practitioners for mental health leadership
- Welcomes all faith traditions

For more information, call 610-361-5208 or visit www.neumann.edu/PhD

---

Aston, Pennsylvania
www.neumann.edu
Self-care in the world of empirically supported treatments
Is it possible that the frequently shallow practice of counselor self-care and the growing reliance on menu-driven, empirically supported interventions are not random parallel processes?

One of the many profound changes within the counseling profession for mental health counselors has been a gradual shift from psychodynamic and person-centered therapies to an emphasis on the medical model. The full history of this shift is an interesting one, featuring as much sociopolitical influence as scientific influence, but that is beyond the scope of this article. The end result of this shift is a focus on diagnosing and matching treatment interventions to the diagnostic criteria. Those who were focused on efficacy and efficiency in the early stages might never have imagined the unintended consequences of their best intentions.

Today, our graduate students are preparing to work in a world in which diagnosing according to the latest established criteria and then matching the appropriate brief, empirically supported interventions to those diagnoses are paramount. For students and new professionals, this reductionist approach might make it seem as if mental health treatment is a very straightforward process of applying Technique A to Problem B.

Medicalized mental health frames diagnostic criteria as signs of illness to be wiped out rather than indicators of pain to be uncovered, addressed and integrated. Symptoms are problems in themselves rather than signs of problems of being. This mechanization of mental health care can have strange effects on counselors. One in particular — the focus of this discussion — is the stultifying effect that reductionism can have on self-care.

Self-care is a standard topic in introductory graduate counseling courses, practicum courses, internship supervision sessions, professional trainings and the professional literature. Nearly every week, I receive invitations to participate in a survey on self-care for dissertation research and receive several offers of continuing education courses on the same topic. Ubiquitous a topic as self-care may be, the definition seems to be so broad that, as with a client’s complaint of depression, no two people can be sure that they really understand what the other is subsuming when the murky phrase “self-care” is introduced.

In recent research focused on grief counseling, not yet published, I surveyed counselors ranging from new professionals (less than five years of postgrad experience) to the seasoned (20 years of experience or more). The sample size was quite small, minimizing the generalizability of the findings. Still, one aspect in particular piqued my curiosity: the tendency among less experienced practitioners to confound recreation with self-care. Although recreation is part of self-care, it is not synonymous with the full range of internal and external attention that constitutes all of self-care.

Another pattern in the research was the assertion, most common among newer professionals in my small pool of respondents, that the right intervention (in this case, within grief counseling) would come naturally and they would know what to do or say in session without concern. More experienced therapists were far less likely to subscribe to this option because they shared an awareness that within (grief) counseling there is no single “right” answer that will naturally come to the foreground. In short, the less experienced counselors were more likely to oversimplify self-care and to have a great deal of confidence that they would simply know what to do when faced with client issues in grief counseling. More experienced counselors were more likely to cite a variety of self-care strategies and to be less confident that the correct intervention would simply rise to the surface during counseling.

I suspect the disparate attitudes between cohorts rests in part on the increasing emphasis on empirically supported interventions and psychiatry’s ongoing reductionist approach to the richness of human experience. We do very well in ensuring that our students know the diagnostic criteria and the most
recent research-supported, efficacious interventions that match those criteria. However, we are into perhaps a second generation of counselors who are proceeding with protocols developed by others who are blind to the section of the Johari window that comprises all that is unknown.

**Taking a shallower approach**

A mere two counselor generations ago, our education and training were solidly grounded in psychodynamic theories, with a tremendous emphasis on self-awareness, therapy for therapists and a profound respect for the depth and breadth of the field of therapy. The power of the relationship was emphasized, and this has not lost its importance, as evidenced by the keynote session presented by Jeffrey Kottler and Richard Balkin at the 2015 ACA Conference & Expo in Orlando, Florida. The developers of what comprise the brief therapies were well-grounded in psychodynamic theory.

Subsequent generations of counselors more often give a drive-by nod to theories that involve the unconscious aspects of experience. They can easily be misled to believe that the readily accessed cognitions are all there are to the client’s misconceptions. Unaware of how a leader such as Donald Meichenbaum’s deep knowledge of psychodynamics colors his current research and work with posttraumatic stress disorder, the new practitioner is prone to merely parroting technique. Meichenbaum, or a therapist with a similar depth and breadth of knowledge, will hear subtle cues about the client’s stability, insecurities, capacity for abstract thought and ability to tolerate frustration or ambiguity and then make nuanced adjustments to interventions on the basis of these minute variations in individual functioning. Meanwhile, a counselor whose education has been aimed at providing empirically based interventions for specific diagnoses is tightly gripping the hammer of cognitive-based therapies, in which every problem is a simple case of irrational belief or cognitive distortion to be thumped into a more logical shape.

Is there a risk that a superficial approach in one area will ineluctably contaminate others? Will the new counselor, ill-prepared to wade into the depths of the client and holding an empirically defended disregard for the importance of those depths, mirror this with a lack of insight into the depth of the self?

Many graduate students and new practitioners have taken advantage of personal therapy and other opportunities for reflection and growth. However, when I review a taped session with a counselor-in-training and my question “What was/is going on for you right now in the session?” is met with a blank stare or a recitation of the relationship between the intervention and the client’s issue, I suspect that insight into the internal experience of the counselor was a chapter only skimmed during formation. Likewise, *countertransference* was reduced to a mere vocabulary word or reflexively described as a source of ethical violations. It is rarely considered a source of useful insight when handled properly and brought to supervision, consultation or the counselor’s own therapy session.

When I encounter insufficiency in attending to internal experiences (in counselors and in clients), that insufficiency often co-occurs in the realm of self-care. How, then, do we bridge the gap for students, interns and new practitioners who are attempting to meet the self-care needs of a counselor’s heart, mind and soul through lighthearted socializing or with a stroll in the park?

**A superficial model of self-care**

The awareness of a need is required before any meaningful attempt to meet that need will be taken. The counselor who has decided that emotions regarding clients are “wrong” because they signify “countertransference,” and subsequently attempts to ignore or suppress those responses to the client, is at risk for the very problems that countertransference can spur. Similarly, self-care requires quiet times for reflection, but a counselor who has absorbed the societal bias against introverted behavior may mislabel these quiet times as “isolating.” Busy students and practitioners — like so many of our clients — can no doubt find multiple reasons, from lack of time to lack of finances, to postpone individual therapy, spiritual guidance and peer supervision.

Yet lack of reflection feeds into a deeper ocean of lack of insight. Meanwhile, self-care, dumbed down to socializing and recreational pursuits, skips lightly over the surface, not sinking into the opportunity for deep reflection and its rewards, including insight into self and others. Self-care gets reduced to time spent relaxing with television or friends or, more rarely, exercising or playing outdoors. These are aspects of self-care, but they elude the essence and responsibility we have for a well-rounded and consistent habit of true self-care.

Our professional literature and conferences are rich with articles and experiential trainings on the importance of deep, well-rounded self-care that addresses the whole person: body, mind and spirit. One suspects that, overstretched and desperately in need of self-care, a great many counseling graduate students, interns and professionals are failing to give more than a cursory glance at these offerings because life is overwhelming. Using a superficial model of self-care, they throw interventions at themselves the same way we are trained to toss interventions at client complaints. As with the empirically supported interventions of therapy, many self-care interventions are focused on the immediate, conscious needs — for example, I need to unwind/blow off steam/throw my head back and laugh until my sides ache. These are indeed real aspects of self-care, but they are not sufficient on their own.

I suggest, then, that frequently shallow practices of self-care and the potential problems of relying on menu-driven, empirically supported interventions are not random parallel processes. They are one regrettable, predictable outcome
of an efficiency-focused, reductionist approach to mental health that is not reflective of mental health counseling as a profession. Counselors are historically holistic, incorporating relationships, client strengths and insight into development with an understanding of pathology and treatment.

The current reductionist approach has been imposed on us by larger forces: third-party payers and the American Psychiatric Association. Meanwhile, our accreditation boards continue to emphasize proper formation, and mental health counseling graduate programs always feature foundational courses that include self-care. We must frequently revisit what is meant by self-care, as well as the implications of the various aspects of self-care for personal and professional functioning.

Client care and self-care ought to be rooted in a deep understanding of the human experience and a profound respect and reverence for the unknowable in each of us. A comprehensive self-care practice feeds our deep need to reflect, make meaning from the events of our lives and develop deep connections with others. Information on self-care and its many vital facets is readily available; we must ensure that the next generations of counselors integrate holistic care of the self into the fabric of their beings and the texture of their lives.

Dolores “Lori” Puterbaugh is a licensed mental health counselor and licensed marriage and family therapist who has been in private practice since 1999. She is an approved supervisor for registered mental health counseling and marriage and family therapy interns in Florida and teaches undergraduate and graduate courses in counseling and psychology. Contact her at puterbaugh@mindspring.com or visit her website at drloriputerbaugh.com.

Letters to the editor: ct@counseling.org

A whole-person approach to self-care

The ways in which we meet our self-care needs will vary. The unique preferences, temperament and style of each counselor require a nuanced approach to self-care. Whatever your style, good self-care will encompass the following elements.

Physical: Strive for good nutrition, regular medical care, adequate sleep and appropriate exercise on a regular basis. Choose a few activities that suit your physical condition and temperament. For example, an extrovert might not enjoy long solo runs, whereas an introvert may relish the alone time for reflection and time in nature. Frequency: Daily practices.

Psychological: Have colleagues with whom you can meet and debrief on a regular basis. Consult with others. Have a therapist or supervisor to help you process the issues raised by your work with clients. Frequency: Weekly, meaningful interaction with colleagues or supervisors.

Social: Meet your social needs in the ways that suit your personality. Failure to meet your social needs outside of therapy will leave you vulnerable to meeting your needs in the therapy room. Frequency: Know your personality and adjust accordingly. Extroverts will need more contact to feel refreshed, whereas introverts will need more quiet after a day of interaction.

Emotional: Have a few people with whom you can be emotionally honest and feel the safety of mutual support. Frequency: Daily contact of some kind with a member of your inner circle.

Creativity: Seek a regular outlet for creativity that is wholly separate from the creativity required in the therapy room. Thinking outside the box in one area will enhance your creativity in the professional area, and investing energy into this kind of play is a way to refuel your spirit. From gardening, woodwork and music to haiku, drawing and cake decorating, the options are endless. Frequency: At minimum, a session of at least a couple of hours once per week.

Intellectual: Years ago, an instructor advised me to expect to spend 10 percent of my professional time reading and learning for the rest of my career. Make a habit of trying to learn something new about the profession every week. Frequency: Ten percent of the time you spend working, which includes reading, watching truly educational video presentations and earning continuing education units.

Spiritual: Nurture this aspect of yourself through whatever discipline is appropriate, whether it is the observation of an established religion or spending adequate time for reflection, meditation and quiet separateness from the busyness of life. Frequency: Daily.

Sound like a lot? We ask this of our clients; perhaps asking less of ourselves is not asking enough.

Imagine yourself well-fed, well-exercised and well-rested. You are regularly surrounded by supportive and insightful colleagues and have a safe place in which to explore your thoughts, feelings and memories as affected by counseling clients. You enjoy regular, meaningful contact with the people you love. You find your creativity blossoming in ways you may not have enjoyed since childhood — or certainly not since graduate school — and your counseling skills seem rejuvenated. At the same time, a regular stream of new ideas and research informs your work and challenges you to stretch your portfolio of techniques. With all this constant growth and change, the quiet time you spend in reflection, meditation, prayer or journaling becomes all the more precious as a way to integrate the totality of your life.

This is the self-care we want for our clients, our loved ones, our students, our colleagues and, yes, for ourselves.

— Dolores “Lori” Puterbaugh
COMING EVENTS

ACA-Asia Pacific Counseling Conference
June 18-19
Singapore
The American Counseling Association-Asia Pacific Counseling Conference is an inaugural conference organized by ACA. Themed “Being an Effective and Resilient Counselor,” this is an excellent platform for discussion between Asian and international mental health practitioners. If you are a counselor, psychotherapist or psychologist, join us to be a part of ACAs international conference. Network and learn from international opinion leaders in ACA, and explore similarities and differences between counseling in the Pacific Rim and the United States. For more information, visit aca-apcc2015.org.

NCDA Global Conference
June 30-July 2
Denver
The National Career Development Association Global Conference will be held at the Hyatt Regency Denver Convention Center. The theme is “Reimagining Life’s Possibilities: Celebrating First Jobs Through Encore Careers.” The event will include professional development institutes, keynote speakers, presentation series and much more. CEUs will be available. For more information, visit ncdaconference.org or contact NCDA headquarters at 918.663.7060. In addition, NCDA has developed a clinical supervision curriculum for those supervising career counseling staff. This 40-hour curriculum meets the training portion of many state licensing boards’ requirements. Training will be offered as a preconference activity. See ncda.org for an application or email dpenn@ncda.org for more information.

ASERVIC 2015 Conference
July 16-18
New York City
The Association for Spiritual, Ethical and Religious Values in Counseling is pleased to announce its 2015 national conference. Join us in the Big Apple for content, experiential and poster sessions focusing on issues of spirituality, religion, ethics and values in counseling. Prior to the conference, join us for a preconference workshop featuring a panel of guests from the Interfaith Center of New York who will be sharing their perspective on adversity and resilience and offering encouragement for counselors to provide spiritually responsive services to clients. Also, you will not want to miss our luncheon keynote speaker, Teresa Sivilli of the Garrison Institute, who will be presenting on building resilience through compassion. For additional information, please check our website at aservic.org.

FCA Conference
Sept. 10-12
Orlando, Florida
The Florida Counseling Association’s 66th annual convention will be held at the Florida Hotel and Conference Center. The theme is “Ambassadors for Counseling: Serving Others.” A preconference Learning Institute will take place Sept. 10, with the conference running Sept. 11-12. CEUs will be available. Register today at the advance rate to lock in savings. For more information, visit flacounseling.org.

WCA Annual Conference
Oct. 1-3
Cheyenne, Wyoming
The Wyoming Counseling Association’s annual conference, with the theme “Counselors Go the Distance,” will be held at the Historic Plains Hotel in downtown Cheyenne. Save the date and watch for full details at wyomingcounselingassociation.com/annual-conference.

ACES Conference
Oct. 7-11
Philadelphia
The Association for Counselor Education and Supervision will host its biennial conference this fall at the Philadelphia Marriott Downtown. Keynote addresses, educational sessions and preconference workshops will align with this year’s conference theme: “ACES Leadership for Culturally Relevant Pedagogy and Practice.” Find event details, including registration and hotel information, at aces2015.net.

KCA Annual Conference
Nov. 4-6
Louisville, Kentucky
The Kentucky Counseling Association 58th Annual Conference will be held at the Crowne Plaza Airport Hotel. The theme will be “Certified, Licensed and Prepared: KCA Professional Counselors Serving at a Higher Standard.” Raychelle Lohmann, Thelma Duffey and Colman Eldridge III will serve as keynote speakers. Preconference workshops are Nov. 4. The conference will provide a wide variety of breakout sessions in an academy approach for counseling professionals in various counseling settings. Proposals can be submitted online until July 15. Registration includes opening reception, school counselor and LPCC/LPCA luncheons and closing brunch. For more details and registration information, visit the website at kyca.org or call 800.350.4522.

2016 ASGW Conference
Feb. 18-20
Alexandria, Virginia
Take advantage of the early bird rates for the 2016 Association for Specialists in Group Work Conference, “Group Work for a Better World,” now at asgw.org. The conference will be held at the Crowne Plaza Old Town Alexandria, just outside of Washington, D.C. If you are not yet a member, please join and receive the member registration rate.

FYI

Call for journal submissions
The Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling invites submissions for The Journal of LGBT Issues in Counseling. The intent of the journal is to publish articles
that are relevant to working with sexual minorities and that will be of interest to counselors, counselor educators and other counseling-related professionals who work across diverse fields. Topic areas include new research, new/innovative practice and theoretical or conceptual pieces, including reviews of the literature, that reflect new ideas or new ways of integrating previously held ideas. The journal is distributed quarterly. For detailed submission guidelines, go to the Taylor & Francis website at tandfonline.com and enter the journal name into the search engine. For additional questions, contact editor Ned Farley at efarley@antioch.edu.

Call for special issue papers

The Journal of Individual Psychology, the journal of the North American Society of Adlerian Psychology, announces a call for papers to be considered for publication in the forthcoming special issue on individual psychology practice and outcomes. Contents of the special issue will include original experimental or quasi-experimental studies to evince the efficacy of some form of Adlerian practice. In exemplary circumstances, theoretical or qualitative projects related to Adlerian practice or outcomes might be considered appropriate. Please see the instructions for authors at utpress.utexas.edu/index.php/journals/journal-of-individual-psychology. Submissions are to be made directly to the special issue editor. Please email the blinded manuscript, a separate title page and a submission letter to Matthew Lemberger at mels@unm.edu.

Critical Incidents in Integrating Spirituality Into Counseling

edited by Tracey E. Robert and Virginia A. Kelly

“This casebook emphasizes the ‘how to’ in integrating spirituality in work with clients. Robert, Kelly, and their contributors have done an excellent job of addressing diversity issues with a variety of client populations across counseling specialties. This is a highly practical contribution to the literature that I strongly recommend to all counseling professionals.”

—Richard E. Watts, PhD
University Distinguished Professor and Director of the PhD Program in Counselor Education
Sam Houston State University

This compelling casebook integrates critical incidents, spirituality, and counseling with diverse populations dealing with issues across the life development continuum. It offers counselor educators, students, and clinicians a highly useful educational tool for more effective teaching and practice that will foster lively discussion, case conceptualization, and intervention skills.

Using an applied format, the book is organized in seven sections: life span issues, spirituality and wellness, specific disorders, substance abuse, career, diverse populations, and spiritual interventions. More than 50 contributors have been selected either to present specific incidents or to react to them. After each case is described, an expert practitioner answers the questions posed and provides additional insight and alternative strategies. The editors then offer their reflections, providing a concise summary of counseling outcomes.

List Price: $49.95 | ACA Member Price: $34.95
Shipping and Handling: $8.75 ($1.00 for each additional book)

Order Online: counseling.org
By Phone: 800-422-2648 x222 (M-F 8 a.m. – 6 p.m.)
Questions About Islam?

A better understanding of Islam may help you to provide better counseling and care for your patients.

www.peacetv.tv
877 whyIslam • www.TheDeenShow.com
www.twf.org

Islam is the religion of inclusion. Muslims believe in all the prophets of old and new testament. Read the last and final testament, the QURAN (the unchanged and original word of God).

 Mandalynths

Celtic Art Mandalas You Trace Like Labyrinths
Visual-Tactile Focus Tools for Stress, Anxiety, PTSD, Autism, Attention Deficit

www.CelticArtStore.net
Try Our New Mobile App

Help Children Express Their Feelings

Available at amazon.com

www.brightawareness.com/amz
“THE BEST MARKETING CHOICE I EVER MADE”

- T.M., Novato, CA

$0 Set-up Fee/$59 per Month.
NO EXTRA CHARGES. 30-DAY MONEY-BACK GUARANTEE

BUILD YOUR WEBSITE FOR FREE AT
www.TherapySites.com

CALL TODAY 877.231.9658

Search Engine Optimized
Unlimited, Easily Customized Pages
Unlimited Customer Support
Mobile Responsive Website

ACT NOW TO RECEIVE YOUR 6 MONTHS FREE LISTING IN Psychology Today
THE BEST VALUE FOR PASSING
THE COUNSELOR LICENSING EXAMS

From study volumes to mock exams, phone consultations, flashcards, and workshops, the Combo Package provides everything your study plan needs.

OUR GUARANTEE
• The Combo Package includes the exclusive AATBS Money-Back Guarantee

STUDY MATERIALS
• Comprehensive Study Volumes

WORKSHOPS
• Online Workshop Series: Exam Strategies and Content Review

ONLINE MOCK EXAMS
• TestMASTER (NCE) – Includes 5 exams
• CasePRO (NCMHCE) – Includes 18 vignettes

ADDITIONAL STUDY TOOLS
• Exam Readiness Lectures
• Expert Phone Consultation

THE GOLD STANDARD OF EXAM PREPARATION
Learn more at AATBS.COM/COUNSELING or CALL 1-800-472-1931

Reduce Your Test-Related Anxiety and Focus on Your Study Plan at an Upcoming AATBS Workshop

NCE Online Workshop Series
Instructor: Holly Walrod-Whitehurst, MA
July 25, August 1, 8, & 15, 2015 ... Online

FREE NCE Strategies Online Workshop
Instructor: Holly Walrod-Whitehurst, MA
July 11, 2015 ..................................... Online

NCMHCE Online Workshop Series
Instructor: Holly Walrod-Whitehurst, MA
July 26, August 2, 9, & 16, 2015 ... Online

FREE NCMHCE Strategies Online Workshop
Instructor: Holly Walrod-Whitehurst, MA
July 12, 2015 ..................................... Online

Exam Critical Thinking Skills Workshop
Instructor: Kaynor Heineck, MS
June 13 & 27, 2015 - Series A ....... Online

DSM-5 Online Video Workshop
Instructor: Jennifer DeFeo, PhD
Self-Paced ........................................... Online

Free Strategies Workshop
It takes less than 1 minute to save a seat for the next available workshop!
www.aatbs.com/freews.asp

Save 20% on CE Courses*
Discover new practices and stay up-to-date on new medical advances.
Visit www.aatbs.com/CTCE for details

www.aatbs.com • 800-472-1931 • 5126 Ralston St., Ventura, CA 93003

*The 20% off promotion is not valid on Certification Courses, Alliant University Courses, Signature Series Courses, Prelicense Courses, Course Bundles, or CA Book Report Option. Retroactive discounts will not be applied.