

Letter from the Editor(s)

Dear Reader,

On behalf of the co-editors, we are so pleased to offer you the 2014 edition of the Tennessee Counseling Association Journal. We hope the information presented contributes to your knowledge regarding counseling. This is the sixth edition of the journal and we plan to offer many more editions, with the goal of adding to the counseling profession literature.

The purpose of the *Tennessee Counseling Association Journal* remains constant: to promote professional growth and creativity of TCA members, Tennessee counselors, counselors nation-wide, and other helping professionals. We hope the empirical research and expository ideas shared in this journal hearten readers to provide best practices to clients, expand notions of counseling, and share innovative counseling strategies with peers.

The target audience for this journal is counselors in all specialty areas, and we invite manuscripts of interest for professionals in all areas of counseling. We welcome manuscripts that: (a) integrate theory and practice, (b) delve into current issues, (c) provide research of interest to counselors in all areas, and (d) describe examples of creative techniques, innovations, and exemplary practices.

As we complete this edition of the journal, I would like to express my sincere appreciation to Drs. Ronnie Priest and Nancy Nishimura for their contribution as co-editors for the TCAJ. Not only have they contributed to this journal, they have also contributed significantly to the Tennessee Counseling Association and the Tennessee Association for Counselor Education and Supervision. They are consummate professionals who have touched the lives of their friends and colleagues, their students, and the counseling profession in general. I would like to wish them well as they enter into the next phase of their lives – retirement! Thank you for all that you have done to make the counseling profession better.

Sincerely,



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This edition of the Tennessee Counseling Association
Journal is dedicated to Drs. Ronnie Priest and Nancy
Nishimura.



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Acceptance and Commitment Strategies in Emergency Departments: Helping Address Psychosis-Related Consumers

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Consumers with psychosis present to Emergency Departments (EDs) in large numbers and often wait more than 11 hours to see a physician. Acceptance and Commitment Therapy (ACT) is a humanistic, anti-pathological intervention that can be implemented in EDs. It can assist those with psychosis to accept their private events and move toward valued goals. This in turn may prevent their re-admission to EDs and relieve an overburdened Emergency healthcare system.

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Many individuals utilize Emergency Departments (EDs) as their primary treatment source. They can self-refer, be directed by their outpatient treatment provider, or be taken to the emergency department by family members. Individuals may present for a variety of reasons such as medical, trauma, or mental health emergencies. EDs have existed in the US since 1911 when the University of Louisville opened the first "accident service" to address farming and other rural injuries (University of Louisville, 2008). EDs expanded their care to include illnesses in addition to injuries. Today, EDs are present across the US and are charged with attending to a variety of health related concerns. EDs are a necessary and integral component of the US healthcare delivery system. The number of annual ED visits is staggering. For the year 2009, the Centers for Disease Control (CDC) reported approximately 120 million Americans presented to EDs (Hing & Bhuiya, 2012). Statistics indicate a sharp rise in

the numbers of annual ED visits. In fact, the CDC found a 10 percent increase in just one year. Unfortunately, the numbers of US EDs declined by almost 30 percent from 1990 to 2009 (Hsia, Kellermann, & Shen, 2011). Regardless of the reasons for the sizable numbers presenting to US EDs, there is a specific population that warrants attention: those with psychosis-related mental health emergencies.

The CDC's most recent data indicate that in 2009, of the more than 120 million ED visits, 4.7 million of those were for some type of Mental Disorder (Hing & Bhuiya, 2012, p. 12). Mental Disorder is often a generic term that includes exacerbation of a mood or anxiety disorder, agitation, intoxication, suicidal ideation, or psychosis (Zeller, 2010). According to Hackman et al. (2006), those with mental health concerns utilize ED services at a proportionally higher rate than the general population and are more likely to have multiple ED visits (Baillargeon et al. 2008; Chaput & Lebel, 2007). The average ED wait time for all emergencies in 2009 was one to four hours. Regrettably, data indicates much longer times for those seeking mental health services (Hing & Bhuiya, 2012). This was supported by a 2006 survey of more than 300 ED medical directors conducted by the American College of Emergency Physicians (ACEP). Almost 80% responded they boarded mental health patients in their EDs for several hours and some waited up to 24 hours (2008). Other findings indicated that more than 70% agreed that mental health patients require more nursing care than non-mental health patients. Lastly, 90% responded there is a lack of mental health services. These issues present challenges and opportunities for novel interventions. For individuals with a mental health emergency, having extensive wait time can exacerbate their symptoms, thus increasing their distress. Paradoxically, as will be detailed later, the ED wait times can offer clinical opportunities that may prove beneficial to those with psychosis-related complaints.

Individuals with mental health related emergencies present unique challenges to EDs. It should be noted, mental health emergencies may not be as obvious as other visible emergencies. Even one who has psychosis may not be in clear distress. In addition, many medical emergencies can be flushed out through objective diagnostic means such as x-rays and laboratory tests, as well as gathering a patient history. However, with the exception of substance use emergencies, there are no such laboratory tests to determine mood, anxiety or thought disorders. Mental health emergencies are usually diagnosed based on a client's clinical history and/or collateral information gathered from family members, friends, first responders, treatment providers or previous admissions. Thus, the information may be subjective. In addition, some individuals with psychosis may not be good historians when providing details on their complaints. Consumers with psychosis-related complaints present challenges, and opportunities, for novel interventions in EDs.

Psychosis Related Consumers

Serious Mental Illness (SMI) generally refers to those with Bipolar, Schizophrenia and Schizoaffective disorders.

Bipolar disorder affects almost six million Americans (Kessler, Chiu, Demler, & Walter, 2005). Schizophrenia impacts more than two million (SARDA, 2013). Prevalence rates for those with Schizoaffective disorder are less reliable and "Detailed information is lacking..." (APA, 2000, p. 321). However, estimates are approximately one in 100 individuals (NAMI, 2012).

All three disorders have specific symptomology that is listed in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). For those with Schizophrenia and Schizoaffective Disorders, hallucinations and delusions are diagnostic criteria. While not specific criteria, these psychotic symptoms are also common in Bipolar Disorder (Avery, Williams, Woolard, & Heckers, 2013; Keck et al., 2003). Hallucinations are distortions of perceptions and delusions are distortions of thought. Hallucinations can manifest in a variety of ways, but are most often auditory in nature. Delusions often are either paranoid or persecutory in nature. These psychotic symptoms tend to cause significant distress, and impact every aspect of an individual's life.

When a consumer presents to an ED, a medical screening is completed and a medical condition is ruled out. Those who are acutely psychotic, in acute distress or deemed an imminent risk are treated. This most often involves the use of anti-psychotic medications and/or anxiolytic medications (e.g., Zyprexa, Geodon; Xanax, Ativan) (Montoya et al., 2008; Zellner, 2010). These consumers often are monitored for several hours until their symptoms abate or they are admitted to an in-patient behavioral unit for further monitoring and symptom stabilization. In addition, the aforementioned medications often induce sedation. Those who are not in acute distress often sit in the ED waiting area until there is room for them in the main ED.

Following are some facts related to these consumers that may assist ED staff in determining how best to address their needs. Many individuals with SMIs have multiple and complex issues beyond their psychoses. For example, this population has proportionally higher rates of medical illnesses as compared with the general population (Rock, et al., 2007; Szpakowicz & Herd, 2008). Additionally, these individuals are often socially isolated, lacking in family support, and homeless (Folsom et al., 2005; Padgett, Gulcur & Tsemberis, 2006; Timms, 2005). People with SMIs are less likely to be in meaningful relationships or have children (Hutchinson, et al., 1999). Further, they tend to have much higher unemployment rates than the general population (Draine, Salzer, Culhane & Hadley, 2002; Seeman, 2009). Alcohol and substance use are also prevalent among those with psychosis-related disorders (Buckley, 2006; Padgett et al., 2006). Crucially, individuals with SMIs are at a higher risk for suicide (Carlat, 2010; DeHert, McKenzie, & Peuskens, 2001).

Another complicating factor is that those with psychotic disorders are often medication non-compliant. One study asserted non-compliance rates for those with Schizophrenia as high as 80% (Lieberman et al., 2005). This could be due to a

variety of factors; among these may be access to medication due to lack of finances or transportation to treatment providers and a lack of insight into their disorder, which is common to those with SMIs. A final reason for medication non-compliance is the associated side effects. For example, a common atypical antipsychotic medication, Risperdal, lists more than 22 side effects (RxList, 2013). These side effects can be either minor (e.g., chills) or potentially serious (e.g., seizures). For many, these potential side effects far outweigh the benefits of ameliorating the positive symptoms of psychotic-related disorders. For those with psychosis or psychosis-related issues, these confounding factors can exacerbate their underlying mental illness. Finally, one study found that anti-psychotic medications are effective approximately 50% of the time (Kingdon, Turkington & John, 1994). Even when medication-compliant, positive symptoms often continue (Breier, Schreiber, Dyer, & Pickar, 1991). Hallucinations and delusions often impact virtually every facet of the individual's life. Psychosis-related consumers, unless they are acutely psychotic, are not an ED priority and often have extended wait times. Waiting in the ED may exacerbate their suffering and reinforce negative self-image, as they are not being seen in a timely manner and are essentially ignored.

The authors propose some strategies that are not pathology-based, and are both humanistic and empowering. These approaches may alleviate consumers' distress and help them to move forward towards a more meaningful life in spite of psychotic symptoms. Additionally, these strategies may decrease consumers returning to EDs and potentially reduce an overburdened healthcare system.

Acceptance and Commitment Therapy

Steven Hayes developed Acceptance and Commitment Therapy (ACT) and it is one of numerous interventions often referred to as the third wave in behavioral/cognitive-behavioral therapy (Hayes, 2004; Öst, 2008). Others include Dialectical Behavioral Therapy (DBT), Functional Analytic Psychotherapy (FASP), and Cognitive Behavioral Analysis System of Psychotherapy (CBASP). ACT has been included in a list of evidenced-based practices by the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as the American Psychological Association (Hayes, 2008). ACT has very broad application to a variety of client problems such as anxiety, affective, substance use disorders, as well as serious mental illness (Hayes, Strosahl, & Wilson, 1999; Hayes & Strosahl, 2010).

Cognitive-Behavioral Therapy (CBT), along with psychopharmacological interventions, is often the approach used for those with psychotic-related disorders (Smith, Nathan, Juniper, Kingspro, & Lim, 2003; Startup, Jackson, & Bendix, 2004; Trower et al., 2004). CBT aims at helping clients decrease the believability of psychotic symptoms, teach coping skills, and essentially assist clients in controlling their disorder (Bach & Hayes, 2002; Pankey & Hayes, 2003). However, there are several aspects of ACT that set it apart from cognitive-behavioral approaches. First, ACT is a mindfulness-based approach. Mindfulness has been

stated as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (Kabat-Zinn, 1994, p. 4). Second, it includes features of existentialism. Among these are self-awareness, living authentically, freedom, responsibility, and making meaning (Seligman & Reichenberg, 2010). Third, ACT is drawn from Relational Frame Theory (RFT) which posits that language and cognition work in conjunction to form a relational frame, which then becomes learned (Hayes, Barnes-Holmes, & Roche, 2001). Fourth, ACT does not propose that painful events are indicative of pathology and need to be changed (Bach, 2010). Finally, from an ACT perspective, hallucinations and delusions themselves are not the problem; it is the behavior or the functionality of the psychosis that is the challenge and thus the interventional target.

More specifically, ACT examines two normal processes that are inherent in all humans and the cause of most psychological suffering. These are *cognitive fusion* and *experiential avoidance* (Bach, 2010; Harris, 2009; Hayes, Strosahl & Wilson, 1999). Cognitive fusion refers to the tendency of humans to get stuck in a thought so that it tends to dominate and supplant other behavioral regulation. Put another way, individuals have an inclination to fuse an event, and their thoughts about that event, to such an extent they cannot effectively separate the two. An example would be to consider someone who is anxious about flying. Fusing the anxiety about flying in spite of the fact that the actual flight has not occurred means the individual has effectively flown already. In other words, what happens is one has thought so much and deeply about the implications of flying, they cannot separate their present thoughts from the future flight. Experiential avoidance is the idea that humans tend to avoid something disagreeable. Most would agree that avoidance might be briefly effective. However, over time it is not very effective. A clear example is one who is depressed. One way (albeit extreme) to avoid depressive symptoms is to commit suicide. While one may argue that it may work in the short-term, it is not particularly effective long-term. In addition, attempts at avoiding an unpleasant event actually increase distress (Bach & Hayes, 2002; Luoma, Hayes, & Walser, 2007; Pankey & Hayes, 2003).

A final, but critical component of ACT is based in existentialism. The idea is that spending time avoiding or controlling those events and associated pain prevents consumers from living, which are termed valued goals (Hayes, 2004; Hayes, Strosahl, & Wilson, 1999). Often times, those with psychosis expend a great deal of time and effort avoiding or being overly controlled by their private events. Hours, days, and even months pass that they simply will never get back. So by assisting ED consumers in exploring and identifying goals they find important, their psychosis, while still present, may be supplanted by pursuing those goals. Assisting ED consumers in exploring, identifying, and pursuing goals they find important may help to reduce psychosis.

ACT for ED Consumers with Psychosis

As a subset of those presenting to EDs with mental health emergencies, consumers with psychosis-related concerns constitute a population that may be amenable to ACT. ED staff will triage and address those consumers who are acutely psychotic via antipsychotic and anxiolytic medications. The remaining consumers with psychosis have what Zellner refers to as “troublesome symptoms” (2010, p. 35). These include auditory hallucinations and paranoid or persecutory delusions that do not impair consumers to such an extent they cannot participate in meaningful interactions. Bach (2010) and others point out that psychotic disorders are generally difficult to treat and complete abatement of psychotic symptoms is unlikely. It is these low levels of psychosis that often drives many aspects of ED consumers’ lives. As mentioned earlier, those with SMI are often alienated from family, more socially isolated, abuse substances, at higher risk for medical illnesses, and many are chronically homeless. Psychopharmacological treatment non-compliance is high with this population. This is due to a variety of factors such as side effects and limited insight into their disorder (Lysakar et al., 2011).

The ED provides opportunities for using ACT strategies with these consumers. First, many US EDs utilize mental health clinicians such as Licensed Counselors, Social Workers, and Psychiatric Nurses. They are charged with screening and evaluating patients for imminent risk of an individual presenting to EDs. Then, along with ED staff, clinicians make recommendations and dispositions. Second, as mentioned previously, ED wait times for those with low to moderate levels of psychosis may result in them remaining unattended and potentially decompensating in EDs. The ACEP (2008) survey found after being seen and evaluated by a physician they waited from 4 to 24 hours. ACT strategies can be utilized in as little as a few sessions by trained clinicians already stationed in EDs.

Guadiano and Herbert (2005) conducted a study using ACT with 40 hospitalized adults with psychosis that demonstrated both brevity and efficacy. ACT was utilized in three 60-minute sessions. Their findings indicated that compared to control groups who received Enhanced Treatment as Usual (ETAU), “The ACT group showed superiority to ETAU on measures related to affective severity, global improvement, distress associated with hallucinations, and social functioning” (p. 430). A similar study compared ACT to Treatment as Usual (TAU) with 80 adults in an in-patient behavioral unit (Bach & Hayes, 2002). They completed the ACT treatment in four 45-50 minute sessions. Study participants were less likely to be re-admitted into a behavioral unit. Another advantage of using ACT strategies in the ED is it affords opportunities for ED consumers to practice the skills and remediate if needed. In addition, if consumers decompensate to an extent they can no longer participate in the counseling process, they can be pharmacologically treated. Simply presenting oneself to the ED for medication is actually a type of avoidance. ACT, with its understanding and emphasis on addressing avoidant behaviors seems well suited to this population.

The inherent variety of those presenting to EDs with psychosis fits very well with ACT. As Hayes et al. (1999) pointed out "... ACT can be understood as at the level of technique as a collection of exercises, metaphors, procedures, and so on" (p. 15). The implication here is that ACT is quintessentially eclectic, thus fitting very well with the heterogeneity of these ED consumers.

ACT Strategy Implementation

There are numerous studies suggesting ACT may be effective for individuals with psychosis (Bach, Hayes, & Gallop, 2012; Bloy, Oliver, & Morris, 2011; Guadiano & Herbert, 2005; Pankey & Hayes, 2003). ACT is "...inherently optimistic" (Harris, 2010, p. 19). More pointedly, Harris states, "Our clients are not broken, they are just stuck." Most would agree that a visit to an ED is not positive and often the only reason one comes there is precisely because something is broken. Consumers with psychosis may benefit from this paradigm shift.

As mentioned previously, cognitive fusion and experiential avoidance are two central factors in psychological suffering. Applied to those with psychosis, we propose strategies that will address these directly. They are building a trusting therapeutic alliance, applying mindfulness techniques, using metaphors, and moving consumers to valued goals. The authors assert together these will assist ED consumers to move forward (in spite of their psychosis). This, in turn, may decrease the numbers of ED consumers with psychosis, thus decreasing the overall volume of ED consumers. As ACT approaches are discussed, the authors will present consumer (CN) and counselor (CU) narratives to illustrate ACT strategies.

As with any counseling approach, the therapeutic alliance is paramount. Any interaction with a consumer having psychosis should be collaborative. The power differential inherent in an ED often sets the stage for consumers to be disempowered and potentially dependent. This comes from the medical/pathology-based model of hospitals. As mentioned previously, the typical intervention for psychosis is medication (Bellack, 2006). The authors do not dispute that psychopharmacological interventions may help. However, atypical anti-psychotics or anxiolytics do not eradicate affects or cognitions, they only temper them (Luoma et al., 2007) and it is difficult to completely eliminate psychosis (Bach, 2010). From an ACT perspective, the initial intervention involves using the consumer's own experiences. Thus, details on hallucinatory and delusional content are crucial. Once counselors have a clear picture of the hallucinations and delusions, they simply normalize and validate consumer's concerns. ACT counselors assert that disturbing private events are neither exclusive to those with SMI nor need to be changed. At this point, the counselor can inquire as to the function of the psychotic content. In other words, what behaviors accompany the psychosis? Often times, the consumer's psychosis becomes cognitively fused with the real world. In other words, when they hear derogatory or persecutory voices, they tend to fuse those into reality when in fact they may have no such evidence to prove the content of the voices. Once the counselor has normalized and asked for evidence of the veracity of

their fusion, (which they will invariably be unable to do), the counselor can engage in *cognitive defusion* (Bach, 2010; Hayes, Strosahl, & Wilson, 1999; Luoma et al., 2007).

This intervention involves assisting the consumer in separating the psychosis from its overt behavior. It is important to avoid becoming condescending when challenging the truth of his or her beliefs about the psychosis. A hallucination or delusion is just as real and valid as a delusion thinking that people do not like them or an imagined conversation with a loved one or God. In other words, the goals here are to normalize the psychosis and to challenge the connection between the hallucination and delusion and its function. Consider the following exchange between a consumer and a counselor. It will be referred back to as we discuss interventions for those with psychosis. The lead author has conducted more than 7,000 ED mental health evaluations. About 30-35% involved those with psychotic symptoms. This example is fairly representative.

CN - "The voices are telling me I am stupid and I should just give up. They just won't stop. They tell me I can't do anything! I will never have anything and that I am a failure. I feel worthless and that I will never be good at anything. I just want them to go away. I tell them to shut up! Sometimes I will drink some beer or smoke some weed and that helps just for a while, but the voices always come back. My medications help somewhat, but they get expensive and I don't always remember to take them, but I still hear the voices a little. They make me sleepy and lazy. I come here and the doctors help me, but I have to wait a long time."

CU - "I know that waiting here can be frustrating. I bet there are other things you would rather be doing. We can talk about that soon. But first, let me share something with you. I wonder if a lot of people have thoughts they are stupid or no good? For you, though, it sounds as though the voices leave such an impression on you that you simply take that to mean you may as well give up. I guess I am not sure how a voice in and of itself is actual evidence that you are stupid and should simply give up? In other words, a voice is not an absolute truth. However, it can be something you won't let go even if it makes your life worse."

The goal here is to build the relationship while concomitantly beginning to open up the client's awareness of the private event's function. In addition, the counselor is setting the stage for helping the consumer to cognitively defuse their psychosis with its function. From an ACT perspective, when strong relations are made between private events (hallucinations and/or delusions), these fuse, getting tangled with the real world. So, as its name implies, to cognitively defuse is to help the consumer understand that a private event is simply that; not its literal meaning. ACT's aim is to help those with psychosis react differently to their own private events. As the counselor and consumer are exploring the psychosis and its functionality, the counselor may employ mindfulness strategies to assist the consumer in examining his or her psychosis.

In applying mindfulness to psychosis, the consumer would observe, without making an evaluation, his or her hallucinations or delusions. The consumer would accept these as transient experiences and not a definer of him/herself (Chadwick, Newman-Taylor, & Abba, 2005). There are many ways to examine and apply mindfulness to a variety of situations and problems. The authors find the basics articulated by Harris (2009) to be simple and straightforward. Harris introduces mindfulness using three basic instructions: "Notice X, Let go of your thoughts, and Let your feelings be" (p. 160). There are numerous texts that provide instruction in mindfulness strategies. The overall aim from an ACT perspective is assisting the consumer in accepting his or her psychosis. The following example provides a basic approach:

CU- "Here in the ED, you have these voices telling you that you're stupid and you should just give up. What I would like you to do is simply notice the voices for what they are. While they are present, they are but one aspect of what is going on around you. When you begin to think about what they mean then go backwards and simply notice them for what they are; just voices. They cannot hurt you. You have a choice on how much or how little attention you pay to them. As you begin to drift toward your thoughts again and that the voices define who you are and what you do, go back to simply noticing them. As you practice this, you will begin to notice that your negative feelings about yourself and the voices will have less of an impact on your life."

At this point, breathing exercises can be employed. Mindfulness strategies may be new for these consumers and often times they will naturally drift back to thoughts (Harris, 2009). Breathing exercises are useful in slowing this cognitive drift as well as helping consumers stay in the present moment. The counselor may now begin to examine the second aspect of psychological suffering, experiential avoidance. In the example, the consumer reported several control strategies: beer, cannabis and yelling at the voices. As was mentioned previously, psychosis is notoriously difficult to completely eradicate. Attempts to control psychosis are often futile, thus frustrating, and can create hopelessness. They also cause consumers to feel stuck and prevent them from moving forward. This is the fundamental idea behind experiential avoidance. At this point the counselor may explore the consumer's strategies and his or her success/failure in attempts at avoidance. Consumers will most often report the psychosis, while abated for a time, almost always returns. Moreover, those who come to EDs typically are at some level of distress. Many with psychosis may have more intense hallucinations under stress; therefore, traditional talk therapy, if used at all, may likely prove frustrating for consumer and counselor. Metaphorical talk is a central strategy of ACT and provides a gentle and novel strategy to challenge the over reliance on rationality in favor of direct experience. Employing metaphors will often help them see the futility of their efforts. Following are two simple metaphors, applied to the consumer above that illustrates this concept:

CU - "Have you ever seen Chinese Handcuffs? They are small tubes. You slip your first finger on each hand into the open ends of the tube. The more you pull away, as in trying to get rid of your voices, the tighter the handcuffs get. But once you stop pulling and accept the handcuffs, they become loose. What about quicksand? Imagine you are standing in quicksand. The more you struggle to get out, the more you slide down in it and the harder it becomes to get loose of it. When you relax, you stop sinking. Do those sound like what happens when you drink, smoke or yell back at the voices? It may feel like you are getting somewhere, when actually it gets worse."

Metaphors have shown value to a variety of populations, including those with psychosis (Hayes, Strosahl, & Wilson, 1999; Mould, Oades, & Crowe, 2010). They allow individuals to look at their private events from a distance by using metaphors as representations. Metaphors are stories permitting consumers to listen and form mental pictures. Furthermore, they tend to be very non-threatening and allow for rich interactions between consumer and counselor. At this point, the counselor may begin to explore the consumer's valued goals. In other words, if the consumer can accept his or her psychosis, be able to separate content from function, and understand the futility of trying to control their psychosis, what could and would the focus be? Unfortunately, for those with psychosis, valued goals have been supplanted by focusing on their hallucinations and delusions. As Hayes points out, "Once awakened, valuing can become a powerful part of a vital life" (1999, p.204). This is often an exciting part of the process of ACT. If the consumer has been able to understand and accept the previous interventions, the counselor can now explore the valued goals.

Valued goals are important for this population for several reasons. First, valued goals are seen as selecting from a variety of alternatives. For those with SMIs, their alternatives can seem limited. They are often identified by their disorder. Consider the term Serious Mental Illness, for example. A consumer with SMIs' identity is often tied into pathology, medication, hospital, poor or nonexistent relationships and income. Exploring valued goals provides the opportunity to step out of that identity and to form new identities. Second, valued goal are choices. Choices imply the ability to control events. Third, valued goals are purpose driven in that there is a point to a valued goal. If the function and identifying features of psychosis are challenged, then it makes perfect sense to also examine the function and purpose of valued goals. Fourth, the exploration of valued goals demonstrates to the consumer that his or her voice is most important and matters much more than pathology. It is these self-identified valued goals that lead to a more fulfilling life.

Often times, for a variety of reasons, those with psychosis have trouble articulating valued goals. So an exploration of valued domains is helpful. Some examples of these domains are, "marriage/intimate relationships, family relations, friendships/social relations, career/employment, education/personal growth and development, recreation/leisure, spirituality,

citizenship, and health/physical well-being” (Hayes, 1999, pp. 224-225). It is often a challenge to explore and commit to valued goals for someone with psychosis. The number of options may be overwhelming for those who have psychosis. So, counselors are encouraged to begin with the idea of heart and soul when exploring values. Simply put, it means to engage in a deep, passionate, and experiential exercise. This brings the thoughts and feelings to life. This also provides opportunities to observe if the consumer can, in spite of their psychosis, formulate and process his or her valued goals. For those with SMI, they may cycle back and forth between defusion, acceptance, and valued goals commitment. It is important to be patient and monitor for when consumers vacillate.

Discussion

The authors contend that consumers with low levels of psychosis are generally neglected in EDs and counseling interventions are virtually non-existent. This is not unusual as EDs are charged with addressing acute patient concerns and then either hospitalizing them or referring them to outpatient providers. Research has demonstrated some efficacy in using ACT for those with psychosis. However, ACT has not been empirically tested in EDs with consumers and psychosis. Given the volume of ED consumers, the lengthy ED wait times, an overburdened healthcare system, a medical/pathology-based model of psychosis, and the over-reliance on medications, the authors propose this novel approach. If ACT can be utilized in the ED for consumers with psychosis, the benefits to the consumers as well as the ED staff may be significant.

As with any therapeutic approach, quality training is imperative. Many EDs utilize mental health professionals either stationed in the ED or on-call. As mentioned previously, many EDs already employ clinicians. If these clinicians are provided ACT training, then those with low levels of psychosis can be treated with the aforementioned strategies.

While there are potential benefits to using ACT strategies for those with low levels of psychosis, there are some limitations. Those who are frequent consumers may not be interested in any therapeutic method, so caution should be taken when approaching these consumers. Certainly, while intervening, should a consumer decompensate to such an extent that the ACT strategies are ineffective, the consumer should then be addressed by ED staff for a higher level of care.

The present article proposes an approach to address psychosis-related consumers. Studies that test the efficacy of ACT's strategies in EDs would be potentially advantageous and thus recommended. The potential challenges to this approach lie in EDs medical/pathological model as well as general resistance that may come from the medical community. However, the counter to that is the wellness-based philosophy inherent in the field of counseling. In addition, addressing psychosis-related ED consumers can potentially reduce the time and funding spent on those with SMIs.

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Licensed Professional Counselors in Tennessee: Attitudes and Perceptions Regarding Clinical Supervision and Knowledge of the Approved Clinical Supervisor Credential

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This quantitative correlational study examined the attitudes and perceptions of Licensed Professional Counselors (LPCs) and Licensed Professional Counselor/Mental Health Service Providers (LPC/MHSPs) in Tennessee regarding clinical supervision and their knowledge of the Approved Clinical Supervisor (ACS) credential. In light of the need to increase awareness about clinical supervision requirements, training requirements for clinical supervision, and the ACS credential, web-based surveys were administered to potential participants across the state of Tennessee via SurveyMonkey. The Pearson product-moment correlation statistic was computed and revealed that there was a significant positive relationship between attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee.

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The purpose of this study was to investigate attitudes and perceptions held by LPCs and LPC/MHSPs in Tennessee about clinical supervision and their knowledge of the ACS credential. In addition, this study was conducted in an attempt to obtain greater understanding of the attitudes and perceptions of LPCs and LPC/MHSPs in Tennessee related to discerning a relationship between attitudes, perceptions, and knowledge of the ACS credential. The study (a) investigated LPC and LPC/MHSP attitudes regarding State of Tennessee clinical-supervisor requirements, (b) explored participants' perceptions regarding training requirements of clinical supervisors in Tennessee, and (c) used quantitative research methods to determine

whether a relationship existed among attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential.

The results gleaned from this study may benefit clinical supervisors and counselor educators who consult with supervisor-training programs in higher education and licensure boards to establish consistency in clinical supervision standards on a national level. This study also explored existing literature and research about training and requirements of clinical supervisors with emphasis on the differences in the skill sets and competencies of clinical supervisors and supervisees.

Clinical Supervision for LPCs and LPC/MHSPs

In Tennessee, a LPC is a mental health professional that holds state licensure and provides counseling. A mental health provider that holds the LPC/MHSP holds state licensure, provides counseling, has passed the National Clinical Mental Health Counselor Examination (NCMHCE) that is given by the National Board of Certified Counselors (NBCC), and has completed nine hours of course work in diagnosis, treatment, and treatment planning. Furthermore, the clinical supervisor is an independently-licensed mental health professional who is approved by the state licensure board to supervise post-master's degree providers (Tennessee Board for Professional Counselors, Marriage and Family Therapists, and Clinical Pastoral Therapists, 2009).

Clinical supervision is a practice tool that is valued and accepted by professions across an array of mental health agencies (Gonzalez & McLeod, 2008; Milne & Westerman, 2001; Zarbock, Drews, Bodansky, & Dahme, 2009). Currently, the most widely accepted definition of *clinical supervision* was presented by Bernard and Goodyear (1992):

An intervention provided by a more senior member of the profession to a junior member of the same profession. This relationship is evaluative, extends over time, and has simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of the professional services offered to the clients, she, he, or they see and serving as a gatekeeper for those who enter the particular profession. (p. 1)

Milne (2007), however, concluded that the above definition of clinical supervision is not necessarily the best definition, and other authors have argued that there is no clear definition of clinical supervision. Carroll (1996) defined supervision as overseeing or adding "extra" vision to the supervisory process (p. 6), and advised that supervision can be considered training or consultation.

No matter what the professional literature asserts regarding the correct definition, clinical supervision has become an important and accepted part of the professional counseling system (Reeves, Culbreth, & Greene, 1997). Clinical supervision is valuable to the development of new counselors, the progression of the profession, and quality care for clients (Spence, Cantrell,

Christie, & Samet, 2002). Clinical supervision is a form of teaching that includes collaborative problem-solving as well as serving as a modality that teaches supervisees new skills (Wisker, Robinson, Trafford, Warnes, & Creighton, 2003).

The Approved Clinical Supervisor Credential

Professionals have agreed for several years that there should be improved methods to ensure the consistency of supervision training and requirements, as well as methods to monitor and evaluate clinical supervision (Borders, 2005; Dye, 1987). Consequently, in 1987, the Association for Counselor Education and Supervision (ACES) identified procedures to be used in establishing a nationally “approved supervisor” certification program. The findings indicated that a certification program should be developed to promote quality supervision as a specialty of the profession (Dye, 1987). Later, an ACES task force on the Establishment of Standards for Credentialing Clinical Supervisors issued recommendations for such credentialing (Getz, 1999).

The ACS credential was established by the NBCC in 1997. The ACS transitioned to the Center for Credentialing and Education (CCE) in January of 2001. This transition allowed the credential to be accessible to more mental health professionals in counselor-related disciplines. To date, the CCE administers the application and maintenance of the ACS credential (NCCs; CCE, 2010).

The application fee for the ACS credential is \$110 with an annual maintenance fee of \$35. ACS credential holders are listed by registry and certification. There are currently 751 mental health professionals who hold the ACS credential in the United States, sixteen of whom reside in Tennessee. The three purposes of the ACS credential are: (a) to identify mental health professionals who have met national professional standards; (b) to promote the accountability, professional identity, and visibility of clinical supervisors; and (c) to encourage professional growth among clinical supervisors (CCE, 2010).

The ACS credential not only elevates training standards for clinical supervisors, it encourages their use of appropriate supervisory skills. By cultivating a culture of competence among supervisors, the ACS credential establishes a more formal approach to considering supervision to be a specialty in its own right. According to Yegdich and Cushing (1998), the ACS credential also affords supervisors an opportunity to become more responsible and accountable in their practices. In addition, the credential protects and improves the profession of supervision by making supervisors accountable to supervisees and clients (Misom & Akos, 2005; Roberts, Borden, Christiansen, & Lopez, 2005).

The ACS credential is based on competencies, skills, education, and knowledge of those who provide supervision. The guidelines of this credential also outline the benefits to those who want to obtain training in supervision (Magnuson, Black, &

Norem, 2004). The ACS credential can be considered a road map for clinical supervisors to achieve more training and certification in clinical supervision. Although not all states require this credential to practice clinical supervision, it still may serve as a bridge that connects competent and credentialed clinical supervisors to supervisees (CCE, 2010; Corson, 2006).

There are approximately 700,000 mental health providers in the United States. The majority are master's-level providers. Clinical supervisors may use the ACS credential to promote supervision as a specialty practice, focus on training and the supervisor identity, make supervision primary to clinical practice, and become leaders in the field of supervision (Bray, 2009).

Method

Participants

Participants included the total population of 1,685 LPCs and LPC/MHSPs in Tennessee. In sampling the entire population of LPCs and LPC/MHSPs in Tennessee, the risk of any sampling errors was decreased (Best & Kahn, 1998). Moreover, the entire population was sampled because the researcher was interested in determining if a relationship existed between attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential for all LPCs and LPC/MHSPs in Tennessee. Participants were sampled from a public list provided by the Tennessee Board for Professional Counselors, Marriage and Family Therapists, and Clinical Pastoral Therapists that can be readily accessed via the Internet (Tennessee Board for Professional Counselors, Marriage and Family Therapists, and Clinical Pastoral Therapists, 2009).

Participants received an invitation from the researcher requesting their participation in this study. The 1,685 LPCs and LPC/MHSPs were invited to answer the online survey questionnaire. For those LPCs and LPC/MHSPs who did not have an e-mail address included in their contact information, an invitation was mailed requesting their participation in this study that included the link to the survey questionnaire (Alessi & Martin, 2010). A three-phase follow-up sequence was used: (a) an e-mail invitation and/or invitation to participate in the study was sent out; (b) 10 days later, a second e-mail reminder and/or invitation was sent; (c) two weeks later, a third and final e-mail reminder and/or invitation was sent stating the importance of the participant's input for the study. This researcher closed the survey two weeks after the last e-mail reminder and/or invitation was sent out (Invankova, 2007).

Instrumentation

For the purposes of this study, a researcher-developed web-based survey was created to measure the desired variables. The survey questionnaire was web-based and accessed through a website address, which was made available to all LPCs and LPC/MHSPs identified by the State of Tennessee Board of Professional Counselors and Marriage and Family Therapists. Specifically, a professional/encrypted version of SurveyMonkey was used for the web-based survey to provide for

anonymity of participants (Hunter College Institutional Review Board, 2005). For those LPCs and LPC/MHSPs who did not have an e-mail address included in their contact information, an invitation was mailed requesting their participation in this study that included the link to the survey questionnaire (Alessi & Martin, 2010).

This instrument was developed based on the ACS credential requirements, related studies, and relevant literature. A cover letter outlined the protocol and instructions for the study. Participants were asked to respond to demographic questions. In addition, participants were asked to rate several questions individually from one to five with one indicating unimportant and five indicating very important. These items were relevant to education, training, and credentialing in clinical supervision. Response choices to these questions were largely based on the ACS certification standards.

Research Questions

The specific research questions that guided this study were:

1. Is there a relationship between attitudes regarding importance of clinical supervisor requirements and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee?
2. Is there a relationship between perceptions regarding importance of training requirements of clinical supervisors and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee?

Results

Research procedures resulted in 201 completed surveys. Seven respondents were removed from the study because they indicated that their counseling licenses were inactive and/or had restrictions placed on their counseling licenses. Therefore, the final number of participants for this study was 194.

Research Question 1

For Research Question 1, "Is there a relationship between attitudes regarding the importance of clinical-supervisor requirements and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee?" there was a significant positive correlation between attitudes regarding clinical supervisor requirements and knowledge of the ACS credential ($r(192) = +.24, p < .001$). Table 1 contains more detailed responses for the question related to the importance of requirements for clinical supervisors in Tennessee.

Table 1

Attitudes Regarding Importance of Requirements of Supervisors

Response	Ranking				
	1 Unimportant	2	3	4	5 Very Important
Have certification as an NCC?	22.4%	15.5%	21.3%	14.4%	27.2%
Be licensed as an LPC?	8.2%	1.5%	7.6%	16.9%	66.6%
Be licensed as an LPC/MHSP?	2.5%	4.1%	4.1%	15.3%	74.8%
Have a master's degree or higher in a mental health field?	1.0%	1.0%	1.5%	6.15%	92.3%
Complete a graduate-level course in supervision?	3.6%	9.79%	24.2%	24.2%	38.6%
Have received continuing education in supervision?	1.5%	5.1%	13.7%	29.5%	51.0%

Note. NCC = national certified counselor; LPC = Licensed Professional Counselor; LPC/MHSP = Licensed Professional Counselor/Mental Health Service Provider.

Research Question 2

For Research Question 2, “Is there a relationship between perceptions regarding clinical-supervisor training and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee?” there was a significant positive correlation between perceptions regarding clinical supervision and knowledge of the ACS credential ($r(192) = +.26, p < .001$). Table 2 contains more detailed responses for the question related to the importance of training for clinical supervisors in Tennessee.

Table 2

Perceptions Regarding the Importance of Training of Supervisors

Response	Ranking				
	1 Unimportant	2	3	4	5 Very Important
Inform their supervisees of the supervisor's credentials?	1.5%	1.5%	4.08%	10.2%	82.8%
Inform their supervisees of the supervisor's areas of expertise?	1.0%	0.0%	3.6%	16.4%	79.89%
Inform their supervisees about the supervisor's training in supervision?	1.5%	1.0%	10.8%	25.2%	62.3%
Adhere to a code of ethics specific to supervision?	1.5%	0.0%	2.0%	4.6%	92.7%
Receive specialized training in the roles and functions of clinical supervision?	1.5%	4.1%	16.5%	31.0%	47.6%
Receive specialized training in models of supervision?	3.6%	6.7%	19.5%	31.95%	39.1%
Receive specialized training in methods and techniques of clinical supervision?	2.57%	5.67%	18.5%	31.4%	42.7%
Receive specialized training in managing the supervisory relationship?	2.59%	4.6%	21.2%	29.5%	43.0%
Receive specialized training in the evaluation of supervisee competence?	3.0%	5.6%	16.8%	33.6%	41.8%
Receive specialized training regarding evaluation of the clinical-supervision process?	2.59%	7.25%	19.6%	32.1%	39.3%
Participate in their own professional-development activities?	1.0%	0.0%	3.6%	17.5%	78.8%
Participate in their own supervision of supervision?	5.26%	5.78%	22.1%	30.0%	37.8%
Have a minimum of five years postmaster's-degree experience in providing mental health services, with at least 1,500 hours of direct service with clients?	1.5%	3.0%	12.2%	21.9%	62.2%
Possess a recognized national or state credential in clinical supervision?	15.3%	11.28%	26.15%	26.15%	22.05%

For this study, the correlation coefficient r assumed that two variables form a bivariate normal distribution population.

There was also a linear relationship between two variables. However, this correlation was not a measure of causation (Laerd

Statistics, 2011). Table 3 summarizes the correlational relationships between attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential.

Table 3

Summary of Correlations

Correlation	Attitudes and knowledge	Perceptions and knowledge
Pearson	.238	.257
Sig.	.001	.001
<i>N</i>	194	194

Descriptive statistics with an emphasis on the mean, standard deviation, and number of participants for each of the independent variables were used in the analysis of attitudes and perceptions of clinical supervision and knowledge of the ACS credential. The standard deviation for LPCs was generally higher than the standard deviation for LPC/MHSPs. This is due to the size of the LPC sample and greater variance. Mean scores for LPCs and LPC/MHSPs were somewhat lower than overall mean scores for the variables of attitudes, perceptions, and knowledge.

Discussion

The findings indicate a significant positive correlation between attitudes regarding the importance of clinical supervisor requirements and knowledge of the ACS credential and a significant positive correlation between perceptions regarding the importance of clinical supervisor training and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee. Therefore, both null hypotheses were rejected because there was a significant positive correlation between attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential.

For the first major question related to the purpose of this study, “Is there a relationship between attitudes regarding importance of clinical supervisor requirements and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee?” there was a significant positive correlation between attitudes regarding clinical supervisor requirements and knowledge of the ACS credential. This finding may be used as evidence for an increased awareness of the need for supervisors to be experts in the skills and competencies of both counseling and supervision, be effective gatekeepers for the counseling profession, and provide evaluation of the skills and competencies of counselors (Borders, 2005; Johnson, 2007; Magnuson, Wilcoxon, & Norem, 2000).

For the second major question related to the purpose of this study, “Is there a relationship between perceptions regarding clinical supervisor training and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee?” there was

a significant positive correlation between perceptions regarding clinical supervision and knowledge of the ACS credential. This correlation and result may suggest there is a need for more consistent and specific training and requirements for supervisors, more qualified supervisors who can be effective gatekeepers for the field of counseling, and supervisors who can provide more valid evaluation of counselors (Borders, 2005; Johnson, 2007; Magnuson et al., 2000).

Based on attitudes regarding the importance of education, licensing, and credentialing of clinical supervisors in Tennessee, over half of the respondents reported that these areas are very important to clinical supervision. More specifically, the majority of respondents had the attitude that it is important that supervisors in Tennessee complete a graduate course in supervision. Likewise, the majority of respondents also believed that it is important that clinical supervisors in Tennessee receive continuing education in the specific area of clinical supervision. These findings are evidence that LPCs and LPC/MHSPs in Tennessee view the requirements of supervisors as important to the overall mission of supervision: supervisee development and client care. Based on perceptions about the importance of the training requirements for clinical supervisors, the majority of respondents indicated that it is very important that clinical supervisors receive training and practice in clinical supervision.

Based on individual survey questions from this study related to knowledge of the ACS credential, only 20 participants out of 194 knew about the ACS credential, related fees, qualification requirements, and the application process. This finding may represent an increased responsibility for supervisors to facilitate and generate more awareness about this credential.

The responses on individual survey items were consistent with previous studies regarding clinical supervision and the ACS credential. For example, Corson (2006) found that there is a need for improved promotion of the ACS credential. Likewise, Corson indicated that there is a need for more generalized standards of training for supervisors that include both more formal and traditional means of training.

Implications for Practice

Kelly, Long, and McKenna (2001), assert clinical supervision is designed to bring skilled supervisors and pre-licensed LPCs and LPC/MHSPs and LPCs and LPC/MHSPs together with the goal of improving both clinical practice and professional issues. Results from this study indicate that there exist a correlation between attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee. Consequently, the more importance emphasized on requirements and training for clinical supervisors and clinical supervision, the more knowledge professionals will have of the ACS credential. The more knowledge that is obtained about the ACS credential by counselors, the more awareness about training, competence, structure, consistency, and professional identity for clinical supervisors will be instilled throughout the profession.

The results of this study reiterate the findings of the extant literature related to the lack of training, inconsistency among states in training clinical supervisors, and competency in the area of clinical supervision. Based on a lack of knowledge of the ACS credential LPCs and LPC-MHSPs, this study underscores the need for increased awareness relative to the ACS credential. This will enable clinical supervisors to become more qualified gatekeepers in addition to having an enhanced level of professional identity (Magnuson et al., 2000).

Implications for Research

The findings of this research were population-based. This necessitated that the entire populations of LPCs and LPC/MHSPs were included in the study. This allowed for external validity for this study. Logically extended, the findings of this study can be generalized to all LPCs and/or LPC/MHSPs in Tennessee. The study also identified a relationship between attitudes and perceptions regarding supervision and knowledge of the ACS credential.

It should be noted however, that although this study provides useful information about the correlations between attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential, there are limitations that warrant examination. For example, the sample in this study comprised LPCs and LPC/MHSPs in Tennessee, and therefore may not generalize to LPCs and LPC/MHSPs from other states. Similarly, the majority of the respondents to this study were LPC/MHSPs. The majority of the participants also indicated that they did not provide post-master's degree supervision. In addition, a majority of participants reported being licensed for zero to five years. Therefore, this may not be an accurate representation of attitudes and perceptions of those who are actually practicing supervision in Tennessee.

There are several recommendations for building on the findings of this research. For example, this study could be replicated on a national level. In addition, this study compared attitudes and perceptions regarding clinical supervision to knowledge of the ACS credential. Future studies could compare current and actual supervisory practices among LPCs and LPC/MHSPs Tennessee with knowledge of the ACS credential.

In terms of future research, consideration should be given to the inclusion of qualitative studies that focus on the exploration of clinical supervisors and supervisees regarding their attitudes and perceptions about clinical supervision and knowledge of the ACS credential. This may provide more detailed insight into attitudes and perceptions regarding supervision and knowledge of the ACS credential. A research methodology of the aforementioned type would address the need for a deeper understanding of attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential from a more subjective point of reference (Fossey, Harvey, McDermott, & Davidson, 2002).

Recommendations

As indicated in the current study, there is a significant positive relationship between attitudes and perceptions regarding clinical supervision and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee. The significance of this finding is that individuals who provide supervision may refer to this study as evidence that the scope of supervision should be broadened. The results will lead to more importance being placed on requirements for those who provide supervision, knowledge of the ACS credential, and increased quality care for clients.

The findings of this study indicate that formal training and requirements of supervisors should be incorporated into a current, more traditional apprentice model. The findings also support the notion that there should be a heightened awareness across the states for more stringent and consistent requirements for supervisors and the supervision they render to LPCs and LPC/MHSPs. The field of counseling and the practice of supervision would benefit from developing and implementing the ACS credential into supervision guidelines. This would assist in promoting consistency among states regarding the way the practice of supervision is implemented.

Supervisors across the United States would be well-advised to develop and adapt more consistent and structured policies and requirements related to supervision in order to better meet the needs of pre-licensed LPCs and LPC/MHSPs and LPCs and LPCs/MHSPs. This will also increase awareness of the ACS credential by increasing knowledge through training and practice.

In order for the practice of clinical supervision to continue to grow and develop in a professional manner, supervisors must place increased emphasis on knowledge of the ACS credential and the importance of training and competency of supervisors. Supervision is integral to the success of counseling. A clear and well-defined system of supervision that includes specific and consistent training of supervisors, as well as knowledge of credentials that are available to supervisors (such as the ACS credential), will increase the likelihood of quality supervision and excellent outcomes in counseling.

The objective of this quantitative, correlational study was to investigate the relationship between attitudes and perceptions of supervision and knowledge of the ACS credential. Specifically, the central questions for this study were: a) is there a relationship between attitudes regarding importance of clinical supervisor requirements and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee; and, b) is there a relationship between perceptions regarding supervisor training and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee. The results of this study provided statistical support that there is a positive correlation between attitudes and perceptions regarding supervision and knowledge of the ACS credential for LPCs and LPC/MHSPs in Tennessee.

As the field of supervision continues to place more importance on the training and requirements of supervisors, knowledge of the ACS credential will continue to be strengthened. There is an opportunity for those who practice and set guidelines for the area of supervision to enhance the way supervision is provided among all states. Results from this research study has the potential to provide counseling professionals opportunities to determine how to alter the system of supervision to evolve to its potential.

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LGBTQ Training for School Counselors

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This article reviews information related to school counseling and trainings aimed at increasing professional school counselors' awareness, knowledge, and skill related to Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) students. Educational concerns related to LGBTQ trainings affecting counselor training programs and counselor educators are discussed. Considerations for school counselor trainings are offered with regard to LGBTQ knowledge, awareness, and skill. Lastly, limitations regarding the extent of research on LGBTQ trainings for school counselor trainees are presented.

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Extant and resounding research has substantiated that lesbian, gay, bisexual, transgender and questioning (LGBTQ) adolescents are at inordinate and increased risk for suicide, multiple suicide attempts, psychiatric care and hospitalization, poor academic presentation and absenteeism, running away, homelessness, victimization, substance abuse and high-risk behavior for contracting sexually transmitted diseases (STDs) (Berger, 2005; D'Augelli, Hershberger, & Pilkington, 2001; Espelage, Aragon, Birkett, and Koenig, 2008; Robinson & Espelage, 2011; Stone, 2003; Vare & Norton, 1998; Weiler, 2004). However, school counselors in training report significantly lower levels of multicultural competency and sexual orientation competency when compared to community counselors in training (Bidell, 2012; Farmer, Welfare, & Burge, 2013). Further, when compared to

teachers, health care professionals, and college students, school counseling students were found to have lower levels of knowledge regarding sexual minority issues (Schmidt, Glass, & Wooten, 2011).

LGBTQ Competency and Professional School Counselors

Professional school counselors have a vast job description that encompasses many different roles and responsibilities.

The Education Trust (2009) defines school counseling as:

a profession that focuses on the relations and interactions between students and their school environment to reduce the effects of environmental and institutional barriers that impede student academic success. ...

The trained school counselor must be an assertive advocate creating opportunities for all students to pursue dreams of high aspirations. The counselor assists students in their academic, career, social, and personal development and helps them follow the path to success. The school counselor serves as a leader as well as an effective team member working with teachers, administrators, and other school personnel to help each student succeed. The school counselor as consultant empowers families to act on behalf of their children by helping parents and guardians identify student needs and interests, and access available resources. (para. 3- 4)

Given the unique and myriad roles and responsibilities of professional school counselors, it is imperative that they advocate and support *all* students. Research suggests that many school counselors possess negative attitudes about sexual minority individuals (Fontaine, 1998). However, these school counselors are not completely to blame as few graduate programs provide adequate training on this particular cultural group (Frank & Cannon, 2009) and counselors have noted said training deficiencies in multiple recent studies (Bidell, 2005; Day, 2008; Frederick, 2010; Rock, Carlson, & McGeorge, 2010). This is despite the fact that clinical graduate training programs have an ethical responsibility to prepare students to meet the needs of all diverse clients, including those who identify as lesbian, gay, bisexual, transgender, and/or questioning (LGBTQ) (ACA, 2005; ASCA, 2007, CACREP, 2009). Research continues to highlight the discrepancies among school counselors, training, and competency. The authors of the current article would like to, instead, call for a shift in focus to increased understanding of empirically based trainings that will increase school counselors' knowledge, awareness, and skill for working with LGBTQ individuals.

This lack of adequate training has significant consequences that may manifest professionally in a number of ways. For example, in Fontaine's 1998 study, all of the school counselors who reported negative feelings toward the subject of homosexuality reported that they had not previously worked with a LGBTQ student. Considering it is estimated that 10% of the population identifies as LGBTQ (Savage & Harley, 2009), it is highly unlikely that a professional school counselor would work in a

school where no sexual minority students attend. Rather, this could indicate a lack of recognition of LGBTQ students and/or issues present in the school (Farmer et al., 2013; Goodrich & Luke, 2009). Lack of systemic or institutional support in the school context may also be a contributing factor in that school staff often feel unsupported in advocacy efforts for LGBTQ students (Valenti & Campbell, 2009). Further, “schools have a unique position as one of the few institutions that almost all LGBTQ students must attend” (Byrd & Hays, 2012, p. 4).

Additionally, students may avoid counselors who are not receptive to their affectional/sexual orientation. Counselors who are either uncomfortable with affectional/sexual identity issues, or unaware of the issues surrounding affectional/sexual orientation, may either deliberately or unconsciously avoid the topic. “It’s important that school personnel not rest on their laurels, but rather be proactive in continuing to communicate the ‘different isn’t bad’ message across all the grades” (Luecke, 2011, p. 144). Training aimed at assisting school personnel in understanding discrimination with regard to affectional/sexual orientation can assist staff in more appropriately meeting the needs of these students (Singh & Burnes, 2009). Jeltova and Fish (2005) point out:

School staff who may not be very clear about what constitutes antigay harassment and who, therefore, may tolerate antigay behaviors in their students and colleagues will feel that they have firm ground for objecting to these actions once they are educated and trained on how to respond to discriminatory behavior. (p.25)

All school staff members have a role in addressing discrimination and working to make schools safe for all students. School counselors, given their ethical and legal guidelines, play an important role in advocating for such efforts. “The faculty and staff of a school can make or break it for LGBTQ students” (Luecke, 2011, p.142). However, much needs to be taken into consideration when deciding the best ways in which to offer trainings for school counselors. While increasing the knowledge, awareness, and skill of professional school counselors with regard to students who identify as LGBTQ may promote student support and healthy development (Goodenow, Szalacha, & Westheimer, 2006; Teasdale & Bradley-Engen, 2010), due to the multitude of roles, demanding schedules, and financial constraints of school counselors (Butler & Constantine, 2005) it is necessary to offer trainings that are feasible to attend. With this in mind, it may be necessary for training programs to be offered during in-service days or on-site training workshops. This programming is typically free to school employees, offered during the school day with permission from the administration, and conducted for brief amounts of time, such as three-hour segments.

School Counselor Education

Recognizing the potential negative consequences of cultural insensitivity with regard to LGBTQ clients, the counseling profession has responded with standards, position statements, and values supporting not only the need for multicultural

competence for all clients, but also multicultural competence specific to working with individuals who identify as LGBTQ. For example, the American Counseling Association (2005) Code of Ethics F.6.b. states that counselor educators are to make students aware of their responsibilities regarding diverse clients and that counselor educators are to “infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors” (p. 15). The ethical standards specify that counselors need training to increase knowledge, awareness, and skills as related to affectional/sexual orientation issues. Self-awareness is stressed as a means to assist school counselor trainees in understanding and being aware of personal values and their effects within the client-counselor relationship. Another aspect of training supported by the American School Counselor Association’s (ASCA) Position Statement on LGBTQ Youth (2007) involves addressing training around issues that could harm a client such as heterosexism. Rainey and Trusty (2007) discuss the responsibility of counselor educators to watch for and point out heterosexual biases and heterosexism, and discuss the impact these attitudes have on the client, the counseling relationship, and the counselor’s ethical responsibilities. Further, Greene (2007) states, “Perhaps the most persistent ethical and clinical problem in the treatment of LGB clients is the problems of antigay bias. Professional incompetence and lack of training to provide culturally informed and competent services represent other challenges” (p. 196).

Despite the expectations by the counseling field for counselor educators to adequately prepare counselors to meet the needs of LGBTQ clients, the majority of graduate counseling programs do not have specialized training or course work for working with LGBTQ students in the school setting (Fassinger & Richie, 1997; Frank & Cannon, 2009). Kocarek and Pelling (2003) state that when course work is offered it is likely not required. Furthermore, Greene (2007) points out that not all trainings are effective at alleviating antigay attitudes. She states that, “heterosexist thinking and behavior can be exacerbated by training that either ignores LGB issues or attends to them but reinforces old distortions” (p. 182). Consequently, practicing school counselors and school counselor trainees have reported a lack of preparedness when it comes to LGBTQ issues (Bidell, 2005; Burke, 1998). Further, results in a recent study indicated that sexual minority students are viewed significantly less favorably than other minority groups by school staff (O’Connell, Atlas, Saunders, & Philbrick, 2010). Conversely, other research suggests that even counselors embracing affirming beliefs do not have adequate knowledge and skill for working with this particular population, but would be interested in such trainings if available (Farmer et al., 2013).

Researchers have called upon the counseling profession to take action on such lack of training and/or inappropriate training (Savage, Harley, & Nowak, 2005). With recent research suggesting that students entering into counselor education programs possess inadequate knowledge and skills pertaining to sexual minority individuals, it is imperative that the profession

take such action (Schmidt et al., 2011). Complicating this task is the reality that many counseling faculty and supervisors have received limited training related to sexual minority and multicultural issues as well (Kissinger et al., 2009).

In terms of supervision, Burkard, Knox, Hess, and Schultz (2009) point out that 15 out of 17 counselor trainees described having at least one nonaffirming LGBTQ supervision experience during their graduate training. These participants noted an oppressive or biased view of LGBTQ concerns from supervisors. When nonaffirming supervision was conducted, it had harmful effects and “resulted in an impasse during supervision” (p.187). This study also pointed out that the participants indicated inconsistent or nonexistent training in regards to LGBTQ issues.

Conoley (2008) noted that negative attitudes towards LGBTQ individuals are in some cases perpetuated by adults and in turn, are negative models for children and adolescents. Indeed, these negative attitudes permeate our society and unless educators have specifically examined their values related to LGBTQ individuals and all children’s right to a safe and healthy school environment, these negative attitudes will remain (Conoley, 2008).

Meeting the needs of LGBTQ students in the school setting appears to be greatly ignored up to this point (Macgillivray, 2000). Unfortunately, professional school counselors seem to play a role in this lack of support. It has been reported that two-thirds of school counselors held negative attitudes towards homosexuality (Fontaine, 1998). Even though educators and counselors may believe that they display a non-biased, non-judgmental deportment, their negative and heterosexist beliefs, feelings, and attitudes are often still communicated in subtle ways (Fontaine, 1998).

The consequences of professional school counselors who are ill equipped to address the needs of students identifying as LGBTQ are significant. Further, research indicates that “without such knowledge, neither clients nor counselors may comprehend the potential effect of less-than-affirming attitudes or inadequate training” (Matthews & Bieschke, 2001, p. 68). This relates specifically to affectional/sexual orientation and is an area in need of more research. This topic was addressed in 1991 by Buhrke and Douce. The authors indicated that negative attitudes toward gay men and lesbian women held by counselors are not only undesirable, but may in fact be damaging to the clients. Additionally, these less than supportive counselors may misdiagnose these individuals due to their own lack of understanding of psychological or developmental issues specific to this population (Buhrke & Douce, 1991). A more recent examination of this topic further establishes the need for attention. “Counselors who neglect to acquire knowledge, skills, and awareness in working with LGBT individuals are flirting with serious ethical breaches, including inflicting harm on a vulnerable client population” (Walker & Prince, 2009, p. 6).

Additionally, Parents and Friends of Lesbians and Gays (1994) noted that a breach of confidentiality by counselors in regard to affectional/sexual orientation has led some LGBTQ individuals to suicide (as cited in Black & Underwood, 1998). A

negative coming out experience can lead to increased feelings of rejection that can increase mental and emotional distress and risky behaviors (Lemoire & Chen, 2005). Statistics indicate that suicide is the third leading cause of death among all 10-24 year olds and the second leading cause of death among all 25-34 year olds who identify as LGBTQ (DHHS, 2004). Considering these detrimental effects of LGBTQ incompetence by professional school counselors, it becomes imperative that counselor education and professional supervision heed the expectations of the profession's ethical codes, standards, and values. In addition, counselors require appropriate and effective training on LGBTQ clients to increase multicultural competence to meet the growing needs of this client population. "The debate in the counseling literature is no longer *whether* to include training on LGB issues but *how*" (Pearson, 2003, p. 293).

Pearson (2003) calls attention to the lack of recent literature discussing the need for training in the area of sexual minority issues. He states that although this need was recognized in the late 1980s and early 1990s, more recent literature merely repeats those assertions and furthers the need for progress. Building on the existing literature, there is great potential for advancements in our understanding of LGBTQ counseling competence. For example, prior research has repeatedly substantiated the importance of stressing awareness, knowledge and skill in counselor education to promote culturally competent counseling (Sue, 1998; Sue et al., 1982). Earlier research noted the impact of knowledge and training on more positive attitudes toward sexual minority individuals (Kim, D'Andrea, Poonam, & Gaughen, 1998). A link between positive alterations of attitudes, and a decrease in prejudice and homophobia has also been found (Sue & Sue, 1990). A training model for multicultural competency that includes knowledge, awareness, and skill is promoted by Pedersen (2000) and involves a progression from one component to the next. Further, Pearson (2003) outlines the following:

Multicultural awareness affects and is affected by knowledge and skills. Knowledge-based training involves lectures, professional reading material, training videos, or group discussion that provides information on a number of topics including the following: models of LGB identity development, struggles associated with coming out, historical factors of the sociopolitical context, effects of heterosexism and homoprejudice, and issues for LGB couples. (p. 298)

Pearson (2003) notes that "regardless of the training format, activities and assignments that focus on awareness, knowledge, and skills should be incorporated" (p.298). Bidell (2012) discusses the importance of designing and providing education and training on LGBTQ competency customized particularly for the needs of professional school counselors. Thus, training for school counselors focusing on LGBTQ knowledge, awareness, and skills appears to be a necessary place to start in assisting school counselor trainees and professional school counselors in becoming more competent in this area.

LGBTQ Training

Although research indicates that training is necessary to increase knowledge, awareness, and skills, little research has been done on the effects of training school counselors with regard to sexual minority youth (Bidell, 2012; Pearson, 2003). Much of the current literature on LGBTQ issues and trainings is theoretical or conceptual in nature. Specifically, Israel and Hackett (2004) “compared the effects of information based and attitude based interventions on counselor trainee’s knowledge about and attitudes toward lesbian, gay and bisexual clients” (p.179). The results indicated that the participants included in the attitude based intervention described more negative attitudes after the intervention than the participants who did not undergo attitude based interventions (Israel & Hackett, 2004). The researchers stated that perhaps these particular participants did not actually subscribe to the positive attitudes their pretest scores suggested, and the attitude-based intervention enabled participants to report attitudes more reflective of those actually held. The researchers went on to note that more accurate acknowledgement of attitudes held is an imperative step in exploration and change.

This study provides necessary information in seeking to understand how to best assist counselors in training. While critically important, exploring one’s attitudes alone is insufficient at preparing culturally competent counselors. It is felt that the Safe Zone, or Safe Space trainings attempt to incorporate the examination of attitudes, knowledge, and skill. These college campus educational interventions to promote LGBTQ sensitivity and allies among heterosexual students and staff are frequently described but rarely evaluated.

Through quantitative methodology, Finkel, Storaasli, Bandele, and Schaefer (2003) aimed to “describe the implementation and effectiveness of Safe Zone training as adapted for students, faculty, and staff at the University of Denver’s Graduate School of Professional Psychology” (p. 556). However, the study had several weaknesses. No specific research questions were outlined. The article briefly described the two training sessions, but did not specifically outline methods or the research approach and design. Participation and information on how the data was collected is minimal. Students were asked to outline specific actions of “I intend” statements that addressed specific LGBT affirmative actions they would do before their next training session. Percentages of results were reported in terms of the number of students’ intention statements made. Detailed description of the data analysis used in this study was not provided. Several other limitations were apparent in the Finkel et al., study as well. These included the following: lack of a control group, researchers playing multiple roles, no measure of participants’ follow through on the goals they set, and the Riddle Scale (Wall, 1995) was not used in the pre-test/post-test fashion. It was also noted that psychometric properties of the Riddle Scale could not be located. Despite the lack of rigor demonstrated, this study provides a necessary place to start and the results indicated that Safe Zone training has the potential to

increase sensitivity and decrease discriminatory behavior among participants. While further evaluations are necessary for confirmation, it is worth considering the feasibility of Safe Space/Zone trainings for professional school counselors.

To date, there is only one known empirically based study that examines the effects of Safe Space training on school counselors and school counselors in training (Byrd & Hays, 2013). This study used a random control group design with pre and post testing to assess the impact of Safe Space training on professional school counselors and school counselor trainees' levels of competency. This study examined the relationship between LGBTQ competency and awareness of heterosexism and sexism. Clear research questions were outlined and examined. The authors controlled for previous training in order to account for preceding education, various levels of experience, and previous background on this topic. By controlling for previous training, this assisted in the authors' ability to isolate effectiveness of Safe Space and to further evaluate the trainings efficacy in relation to knowledge, awareness, and skills related to LGBTQ individuals. A rigorous research design and data analysis protocols were implemented. Limitations, implications, and future research were discussed.

Training and Knowledge, Awareness, and Skills

Byrd and Hays (2013) used the Gay Lesbian and Straight Educational Network (GLSEN, 2006, 2009) Safe Space training in the study to train professional school counselors and school counselor trainees. It is felt that the Gay Lesbian and Straight Educational Network (GLSEN, 2006, 2009) Safe Space 3-hour training addresses the many elements needed for enhancing knowledge, awareness, and skills among professional school counselors. Components shown to be successful in increasing knowledge, awareness, and skills consist of self-reflections of beliefs and attitudes held about LGBT individuals (Dillion et al., 2004). Exploring early messages one received as a child about LGBT individuals and challenging beliefs and/or biases held is another important piece of training (Pearson, 2003). Acknowledging and discussing benefits and challenges to coming out (Callahan, 2001) and exploring anti-LGBT bias, homophobia and heterosexism (Phillips, 2000) are other crucial parts to the training. The GLSEN (2006, 2009) Safe Space training does all of this and more while asking participants to be reflective, and share in small and large groups if desired. The sharing process can further learning from others and can assist in providing participants with expanded perspectives and more information.

Incorporating training that specifically addresses skill building and competency can include role-playing exercises and case studies (Pearson, 2003). DePaul, Walsh, and Dam (2009) discuss the importance of school counselors' role in educating teachers and school staff on issues related to sexual minorities. For example, they address the school counselor's role in teaching staff how to intervene when the common saying, "that's so gay," is used and how not responding to such comments from students can appear to perpetuate homophobic ideas. They also note that the response to this common phrase need not

stifle conversation or make students feel as if discussing LGBTQ issues is inappropriate. However, such techniques can be nonexistent in schools if school counselors have not been educated or trained in such areas. The information presented in the GLSEN (2006) training does just that and asks participants to role play responses to homophobic remarks or behavior.

Another component of education and training specific to LGBTQ issues deemed important is information for counselors on breaking the silence about heterosexism, prejudice, and homosexuality (Callahan, 2001). The GLSEN training calls participants' attention to the importance of language and use of terminology. Specifically, the training guide discusses the importance language has on how individuals view and understand themselves and also on how individuals discuss and describe concepts in correct and respectful ways. The purpose of one of the activities in the training is to introduce these concepts and help participants understand terms related to LGBTQ individuals to become familiar and comfortable with these concepts. This is an important activity in the training and can promote positive school climate by assisting school counselors in understanding terminology, pointing out the importance of inclusive language, and challenging stereotypes (DePaul, Walsh, & Dam, 2009).

Safe Space Implementation

The GLSEN Safe Space Training Kit is easily obtainable on the GLSEN website at the following address: <http://www.glsenstore.org/safe-space-kit.html>. To effectively implement GLSEN Safe Space trainings for school counselors, their roles must be taken into consideration. Typically having astronomical case loads, a multitude of job responsibilities, little support in terms of clinical supervision, and inadequate pay (Butler & Constantine, 2005), trainings must be offered during times that are approved by the school administration, do not detract from other responsibilities, and minimize stress. To achieve this, trainings may be offered during pre-service days offered by most school systems just prior to the start of each new academic year to allow faculty and staff to prepare for the arrival of students and receive trainings. Alternatively, most school systems schedule in-service days throughout the year that provide faculty and staff with additional trainings to enhance professional development. Early advocacy for inclusion of GLSEN Safe Space trainings being included in one of these already designated time slots may maximize school counselor attendance. In addition, assuring that trainings are designated to count toward required professional development continuing education credit would promote not only attendance but also program credibility.

Making the trainings cost effective, and most preferably, free of charge may also contribute to training attendance. Qualified facilitators may be located at local colleges and universities, other surrounding school districts already implementing the trainings, or through the GLSEN organization. Local clinical counselors invested in advocating for LGBTQ rights may also be invested in promoting the competency of school counselors and thus interested in conducting Safe Space trainings. Most feasibly, a school system's counseling program director could implement the trainings.

Summary

Stone (2003) calls for school counselors to have professional development in regard to understanding what makes a school environment negative and how to promote a positive school climate that supports all students and provides equal opportunity to learn, grow, and develop. "Counselors in schools have the daunting but imperative obligation to become social activists for gay, lesbian and bisexual students, because these students may well be the most stigmatized members of the school environs" (p. 145). In order to provide students with the protective features known to decrease mental health issues, counselors need to be trained in how to advocate and provide a positive school climate for LGBTQ youth.

Although research indicates that multicultural competency includes knowledge, awareness, and skill, little research exists on what is effective to promote this competency among school counselors in relation to sexual minority youth (Pearson, 2003). Much of the available literature is conceptual; however, what is resounding in the literature is research outlining many risk factors associated with heterosexism, which lead to sexual minority youth being more susceptible to abuse, violence, harassment, drug use, depression, and risky sexual behavior (Kosciw, Diaz, & Greytak, 2008). Yet research has also indicated that supportive school climates may play a protective role in the lives of LGBTQ youth (Goodenow et al., 2006; Teasdale & Bradley-Engen, 2010).

Due to the current research supporting a training consisting of multiple components (Finkel et al., 2003) and the research presenting somewhat mixed results (Israel & Hackett, 2004), coupled with the general lack of research in this area (Pearson, 2003), an increase in understanding training needs appears necessary. Considering the dire outcomes for LGBTQ youth are compelling reasons to examine whether this type of training can make a difference. Byrd and Hays (2013) offer the first of its kind in the way of empirical evidence of a best practice training for school counselors to specifically increase knowledge, awareness, and skill of LGBTQ competency. As a result, the profession as a whole, specifically practicing school counselors, counselors in training, and counselor educators now has an evidence-based training for use in personal growth and professional development (Byrd & Hays, 2013). Providing professional school counselors and school counselor trainees with training specific to the needs of sexual minority youth is essential. Further, the authors echo (Byrd & Hays, 2013)

as a profession, school counselors in training, professional school counselors, and counselor educators can no longer expect to progress while simply repeating the call to action heard over the past few decades or blaming school counselors for their lack of training. To advocate for LGBTQ youth, is to advocate for adequate competency training such as the one presented. (p.28-29)

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The Use of Play Therapy in Children Experiencing Emotional Trauma: A Primer for Counselors

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Childhood trauma is a prevalent occurrence which can lead to long-term personal struggles if the traumatic event goes unresolved. Research suggests that it is important for children to receive age appropriate counseling modalities that allow them the opportunity to process and express their responses to trauma related experiences. One effective counseling modality is play therapy. Play therapy allows children the opportunity to use their natural language of play to express their thoughts, feelings, and behavioral manifestations related to the trauma. The purpose of this article is to offer an introduction to the concepts of play therapy as an effective treatment modality for children who have experienced trauma.

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Childhood trauma is a prevalent occurrence in today's society (Morrison, 2009). It is estimated that over fifteen million children are at risk for Post-Traumatic Stress Disorder (PTSD) (Morrison, 2009). Morrison goes on to argue that children who experience some sort of trauma have negative views of themselves, others, and the world. It has also been shown that unresolved childhood trauma can lead to long-term personal struggles that include, but are not limited to, impairment of social functioning, emotional development, and success in areas of academic achievement (Kaplow, Saxe, Putnam, Pynoos, & Lieberman, 2006). In order to assist children in coping with, and eventually overcoming the impact of a traumatic event, it is important that they receive counseling services that have been shown to be most effective in mitigating the damaging impact of traumatic events.

Norton, Ferriegel, and Norton (2011) argue that the specific impact of traumatic experiences during childhood make it difficult for children to access verbal recall. This factor serves as a serious impediment to more traditional forms of counseling interventions. Additionally, children are developmentally different than adults and they require forms of counseling that allow for them to express their thoughts and emotions in developmentally appropriate ways (Reyes & Asbrand, 2005). Therefore, counselors need to utilize counseling modalities that allow children to access, and then express, the post-trauma inner turmoil with which they have been left as a result of the trauma. Play therapy is one such counseling modality. Reyes and Asbrand (2005) describe play as embodying a naturalistic means for children to express themselves. Employing play as a primary counseling modality gives children better access to processing traumatic events that they may have experienced (Elkind, 2007; Glazer, 2010). In addition, Reyes and Asbrand (2005) state that play is not only a learning process for children, but an automatic response that allows children to explore their internal and external worlds, discover skills and abilities, learn the rules of social interactions, and express the complex nature of their experiences that they may not be able to directly voice. The purpose of this paper is to offer an introduction for counselors who wish to explore the use of play therapy when counseling children who have experienced some degree of trauma as an effective treatment modality.

Review of Literature

According to Halstead, Pehrsson, and Mullen (2011), life is rife with difficult struggles with which children must cope. These life struggles are thought to originate from two basic categories of problematic experience. The first type of problematic experience occurs when one does not receive that which one needs or wants. This type of experience can get processed by the child as rejection and a form of neglect. The second type of problematic experience is receiving that which one does not need or want. Extreme examples of this situation would be physical or sexual abuse. The more extreme cases in either category can leave a child traumatized.

Childhood trauma can be defined as a new and unexpected event that creates an outpouring of emotions (Morrison, 2009). Because the traumatic event is so overwhelming, it serves to break down a child's coping and defense mechanisms, which in turn can leave him or her feeling helpless and lost (Terr, 1991). Morrison (2009) found that children who are continuously exposed to a wide range of traumatic events on a daily basis are profoundly affected. Events such as surviving a natural disaster, physical or sexual abuse, domestic violence, life-threatening medical conditions, or constant exposure to community violence, have been shown to not only negatively impact a child's ability to cope, but also limit his or her emotional, physical, and cognitive development (Morrison, 2009). Shen and Sink (2002) suggested that traumatic events, such as the ones denoted above, along with the painful emotions they elicit, often lead to exhibiting symptoms of PTSD. Children suffering from

PTSD as a result of experiencing a traumatic event often exhibit the following behaviors: increased clinginess, crying out of fear of separation from their parents, increased levels of aggression, change in personality including being extremely withdrawn, easily frustrated, more difficult to engage and comfort, changes in eating patterns, and nightmares that often lead to sleep disturbances (Lieberman & Knorr, 2007; Dugan, Snow, & Crowe, 2010). Similar behaviors have also been found in children suffering from traumatic loss. Glazer (2010), for example, described behaviors of grieving children to include fear of separation from their parents, a sense of insecurity and abandonment, developmental regression, and emotionally explosive expressions.

Due to limitations inherent in the early stages of human developmental, children often do not conceptualize life events as adults do. Take, for example, the death of a loved one. An adult is able to appreciate the finality of death. On the other hand, according to Green and Connolly (2009), a very young child conceptualizes death as reversible and it is normative for him or her to engage in magical thinking about the return of a loved one. Therefore, it is important for the counselor to recognize such elements in first formulating an understanding of how children construct meaning (Halstead et al., 2011) and the limited nature of a child's communication skill repertoire that will allow him or her to deal effectively with traumatic exposure (Glazer, 2010; Ogawa, 2004). Early exploration into clinical work with traumatized children served to advance the importance of incorporating play into the counseling process (Terr, 1979). Play therapy has been suggested as a unique and developmentally appropriate method to use with children to ensure they receive the help needed to navigate their world and work through traumatic exposure. Play has been widely used in helping children to understand the nature of their problematic experiences (Halstead et al., 2011).

Use of play as a primary vehicle in, or as an adjunct to, the counseling process has a historical foundation and research base that supports its use in working with children suffering from a traumatic event (Bratton, Ray, Edwards, & Landreth, 2009). Snow, Wolff, Hudspeth, and Etheridge (2009) found that play therapy is supported by clinicians as being a developmentally appropriate counseling approach for children. This form of intervention allows children to use their natural language of play in a safe environment to work towards overcoming the symptoms that were elicited from experiencing a traumatic event. Norton et al. (2011) explain this further by suggesting that the neurological impact of the traumatic experience itself requires a more physiologically based and movement oriented intervention which play interventions provide. This approach allows children to use their innate ability to choose how they wish to express thoughts and feelings (Ogawa, 2004; Street & Sibert, 1998). Bratton et al. (2009) state that play therapy is a broad-based and useful counseling modality that has been employed successfully in working with children from a wide variety of different cultures who have experienced a range of traumatic events.

Ogawa (2004) explains that play is the way in which children communicate to others about their inner world. Given that children tend toward more concrete constructions of their inner worlds, they do not have the same capacity as adults for using language to verbally express and process their internal struggles. Rather, children need to be given opportunities to communicate through the language of play, in more concrete ways such as tactile media, free movement, interaction with toys, and engaging in games (Landreth, 2012). Because play provides a developmentally appropriate form of expression, counseling interventions that utilize this modality have been found to be an effective way for children to work through their painful emotions and experiences (Reyes & Asbrand, 2005). Use of play within the context of the counseling process can serve to build rapport and engage a child client in a manner that does not rely as much on receptive and expressive verbal skill that exceed the child's developmental level (Halstead et al., 2011). Knell and Dasari (2010) explain that by engaging children in a process of using toys and movement as their "words" in play, they are better able to effectively articulate the thoughts and feelings generated by troubling events in their lives. The reason for this is because play is something children engage in automatically as they discover new social skills, learn rules for social interactions, understand their internal world, explore their external world, and find ways to connect their internal and external worlds (Reyes & Asbrand, 2005). During therapeutically facilitated play, children reenact and convey their traumatic experiences through behaviors and ways in which they interact with the environment (Green, Crenshaw, & Kolos, 2010). Therefore, in order to understand the behaviors they exhibit and begin to help them work through a traumatic event, the counselor needs to use developmentally appropriate techniques that embody play.

Shen and Sink (2002) argue that children experiencing PTSD need a specialized form of counseling that focuses on their personal and social development. Play provides children with a supportive environment to, in a sense, play through the traumatic event and re-experience the feelings it elicits, and thus the counselor joins the child's world to help support the healing process (Morrison, 2009). When the counselor is able to enter the child's world, the counselor-child interaction becomes more important and powerful than the traumatic event (Shelby, 1997). Play in counseling provides children with the supportive environment that they need to overcome the trauma in a naturalistic manner and thus the counselor is let into the child's world to help support the healing process (Morrison, 2009). Dugan et al. (2010) found play therapy to be a successful form of treatment in working with children exhibiting symptomatic manifestations of anxiety, depression, trauma, and overly aggressive behaviors.

Differing Forms of Counseling that Utilize Play

In general, play therapy is a form of counseling intervention that gives children the opportunity to more fully express themselves and work through feelings and experiences that they may otherwise not be able to express (Morrison, 2009). There are numerous specialized forms of play interventions that have been shown to be effective in working with children suffering from

the effects of trauma. Although the scope of this article does not allow for an in-depth exploration of all the various forms of play interventions available to counselors, provided below is a very brief overview of three that capture broad elements that one should consider when engaging children in a play oriented counseling process.

Cognitive Behavioral Play Therapy (CBPT), as the name suggests, is based on the tenants of Cognitive Behavioral Therapy (Knell, 1998). Knell and Dasari (2010) describe CBT as focusing on helping an individual change cognitive meaning-making schema so that more adaptive perspectives can be incorporated into one's thinking patterns. This type of core change helps an individual in reframing the thoughts attached to an experience and in turn serves to inform more adaptive cognition. This process results in qualitatively different affective responses, action oriented decision-making, and ultimately one's behavior (Halstead et al., 2011). In order for cognitive behavioral therapy to be used effectively with children, some level of adaptation to adult focused CBT was necessary. Modifications revolved around establishing a focus that was appropriate for cognitive-developmental stages most consistent with childhood and then infusing the use of play into the counseling process (Knell, 1998). The result was the creation of CBPT. CBPT has been demonstrated to be an effective form of treatment for not only helping children suffering from a traumatic event, but also for counseling children suffering with separation anxiety, depression, anxiety disorders, phobias, sleep problems, and encopresis (Knell & Dasari, 2010).

Child-Centered Play Therapy (CCPT), emerged out of Carl Rogers' therapeutic technique of Person Centered Therapy (Bratton et al., 2009). Rogers posited that all individuals have the ability to work towards self-actualization as long as the proper core conditions exist within the counseling relationship (Nystul, 2010). Axline (1947), a student of Rogers', pulled from his work and research to adapt the client-centered counseling process to incorporate play. Axline's work led to CCPT being a respected and effective form of treatment that is employed by counselors who work with children who have experienced traumatic events. In addition, through the use of acknowledging and focusing on the child, not the problem, CCPT has been found to be effective in enhancing the child's knowledge and acceptance of him or herself (Bratton et al., 2009). Axline (1969) proposed specific principles that serve to guide CCPT, which include the following elements: developing a warm and friendly client-counselor relationship, accepting the child without conditions so as to free the child to express feelings, reflecting feelings so that the child gains insight, respecting the process of the child's ability to problem solve and to institute change, following the child's lead in play, and establishing limitations only to reinforce awareness of the responsibility the child has in the relationship. This framework has been adopted as a mainstay for orienting play when counseling children.

Counselors who work with children know that it is very important to include the primary care takers in the counseling process. More formal involvement of caretakers in play therapy is an intervention known as Filial Therapy. Filial Therapy was

developed by Bernard and Louise Guerney in the 1960s and is based on Client-Centered Play Therapy (Glazer, 2010). Guerney (2000) stated that the relationship with the parent or caregiver is the most significant relationship a child has and is a powerful vehicle when utilized appropriately in counseling. Therefore, Filial Therapy stresses the importance of the parent-child relationship, and under the counselor's guidance and supervision, the parent becomes the child's primary counselor (Glazer, 2010). Glazer goes on to suggest that the parents' involvement is extremely important because of the significant emotional attachment the child has with the parent. Guerney (2001) also suggests that every effort should be made to involve non-offending caregivers in terms of educating them so that they will be more effective in their role. The process in Filial Therapy involves the parent and the child, with the guidance of the counselor, working through each element of the traumatic event, exploring the meaning and emotions the event has left with the child, and learning new ways to engage in growth oriented work (Glazer, 2010). Since parents are significantly involved in the counseling process, after termination, parents have the option to continue using the tenants of Filial Therapy at home to benefit the child. Through Filial Therapy, the parent-child relationship is strengthened, the parent gains education around how to be a more effective parent, and the child is supported in working through the aftermath of the traumatic event.

Despite the fact that there are a variety of specialized forms of play therapy, when taken more collectively, there are several necessary elements that need to be present for counseling to be effective. These necessary elements are consistent when working with any child suffering from PTSD or any sort of traumatic event. The first element is the personality characteristics of the counselor, which helps establish the client counselor relationship. Fitzgerald, Henriksen, and Garza (2012) stress that, as in any form of counseling, the effectiveness of play rests largely on the client-counselor relationship and less so on the specific interventions a counselor might employ. The client counselor-relationship is especially important when working with children who have been traumatized in that they can be very sensitive to their social environment. It is important, therefore, for the counselor to create a secure bond with the child. Engaging the child gradually, physically moving to the child's eye level, and allowing the child to choose which toys he or she wants to play with, and initially allowing the child to guide the play, have been found to be effective in helping to establish the basis for the counseling relationship (Bratton et al., 2009; Fitzgerald et al., 2012).

Second, the counselor should work toward following the child's lead when it comes to play. Doing so not only provides access to the child's motivations, but it also provides for the opportunity to explore the themes that tend toward being the most problematic for the child (Halstead et al., 2011). Finally, it is important to recognize that a child's life is always contextualized by the home environment. Involving caregivers in the helping process either directly or non-directly is a key factor in helping to

ensure that any gains made in session are reinforced at home and that caregivers can appropriately provide for the needs of the child working through the aftermath of a traumatic experience (Guerney, 2001).

Stages of Play in the Counseling Process

Given that play interventions with children take place within the counseling process, it is important to recognize the stages that the child will likely move through as a result of effective work. Although stages may vary in duration, and movement from one to the next is a gradual process, a stage model is advantageous in that it provides a sense of how the child is progressing over time and what one might anticipate over the duration of sessions. Guerney (2001) proposed that there are four stages through which a child will move. The first stage is the Warm-up Stage in which the child is seen making contact with the counselor within the context of the play setting. This “getting to know you” period is important in that it serves to help form the working alliance between the counselor and the client. Next is the Aggressive Stage. According to Guerney, it is in the Aggressive Stage that the child begins to express the true nature of their inner experience. The hallmark of this stage is the child acting in a defiant manner, high-energy play, or being verbally and physically aggressive with play objects. The third stage is the Regressive Stage, in which the child pretends to be much younger and someone who is dependent and in need of care in one form or another. Guerney’s final stage in the counseling process involving play is the Mastery Stage. In this stage the child emerges as someone who takes on responsible roles in play and does so with a good degree of confidence. The child may even state how positive he feels about himself which is a clear leap forward from the Regressive Stage. In the Mastery Stage, the nature of the child’s play is more consistent with the current age and developmental stage. It is important to note that the stages that Guerney posits are thought to be linear in nature but not unidirectional. The counseling process supports the child’s movement from one stage to the next, but the counselor should expect, at points, for the child to make brief visits to previous stages over the course of counseling.

When focusing specifically with children who have experienced trauma, Norton et al. (2011) argue that across play therapy sessions a counselor is likely to observe three clusters of behavior that are directly linked to defending the self against perceived threats from the environment. These cluster of response behaviors include: a) being hyperaware or vigilant arousal, b) mobilizing defense behaviors, and finally c) once the threatening stressor is perceived as no longer present, more normalized behavior emerges.

Given that the counselor’s role is to facilitate movement through the stages of the counseling process and access the cluster of response behaviors noted above, it is essential that the counselor set up a proper play environment to help in this endeavor.

The Play Environment

Landreth (2012) stresses the careful selection of toys with which a counseling playroom should be equipped. The categories and specific types of toys include those that are typically family nurturing toys, such as baby dolls, a play kitchen, dollhouse, people figurines, dolls, cribs, a medical kit, and stuffed animals; communication toys, such as a telephones, walky-talkies, and cell phones; aggressive toys, such as a punching bag or an inflatable punching clown, replicas of typically aggressive animals, and toy soldiers; competitive toys, such as Nerf-ball games, board games, cards for indoor use, and a number of outside game balls when weather permits sessions outside; mastery toys, such as a chalk board, school supplies, building blocks, and coloring books; toys for creative expression, such as art supplies, clay, sand trays, and puppets; and a variety of scary, pretend, fantasy toys, and dress-up clothing (Bratton et al., 2009; Glazer, 2010; Guerney, 2001; Reyes & Asbrand, 2005). There are also advantages to having a section of the play space occupied by smaller sized chairs and tables to enable the child a comfortable environment in which to work. It is also important that the child understands that the objects in the playroom are available for full use during a session. There are times when toys may become damaged as a child acts out at points along the counseling process. This is especially true during the Aggression Stage, and at these times, the counselor must show adequate restraint in processing the child's thoughts, feelings, and behavior (Guerney, 2001). Guerney also posits that the playroom must provide objects and activities that allow the child to express a wide range of emotions as well as exhibit cluster response behaviors across the stages of the counseling process as detailed in the previous section above.

Playroom toys and other objects provide the necessary tools to stimulate a special form of play with which the child will communicate the troubling inner experience. It is through the use of these toys and being in the proper therapeutic environment that children are stimulated to engage naturalistically, and thus gives them ample opportunity to reach their full potential through play. This will, in turn, allow the counselor to begin the process of developing a deeper understanding of the child by interpreting their play within the counseling process (Green et al., 2010). Green et al. go on to suggest that through understanding and interpreting the child's play, the counselor can begin to help him or her work through various elements of the traumatic experience that serve to impinge on other aspects of the child's life. It is also important to note that Guerney (2001) suggests that the specific selection of toys and materials in a play therapy room are less important than insuring that the child is able to make an expressive statement with the counselor during the play sessions across all stages of the counseling process.

Cassie, a four-year-old girl who after being sexually abused by her uncle developed nightmares, began to act out in preschool and withdrew from her friends. Cassie's mom, Terri Lee, brought her to see a counselor who specializes in the use of play when counseling children. During their first session, the counselor introduced the play room and a large assortment of toys

to Cassie and her mom. Guerney (2001) refers to this as the Warm-up Stage. The Warm-up Stage continued as the counselor walked Cassie around the room, talking about and touching all of the toys on the shelves and informing Cassie that these toys were made to be touched and played with as much as she might wish. Cassie began to warm-up to the play room quickly. As her eyes wandered around the room, she discovered the different toys: a doll house, an art corner, a puppet theater, dress-up clothes, a play kitchen, blocks, shelves filled with cars, planes, and trains, and a medical kit. By watching Cassie's eyes survey the room, the counselor was able to detect that Cassie had worked through the Warm-up Stage and was engaged, interested, and ready to play.

Cassie's move to the Aggressive Stage was evident when, upon seeing the "Bo-Bo" doll in the room, she clenched her fist and hit it. Cassie also named a particular puppet she chose "The Scary Guy." At the beginning of each session, Cassie would grab this puppet off the shelf and place it under a large box in the corner of the room. Cassie's physically aggressive action with "The Scary Guy" puppet was seen as a hallmark of the Aggressive Stage. Even though Cassie could not explain in words why she was acting aggressively towards this one puppet, it was evident to the counselor that Cassie was expressing an important aspect of her inner experiences and taking action in response to those stressors.

Even though it seemed Cassie was making progress in counseling and working through the Aggressive Stage, she then entered into the Regressive Stage. This was detected by the tantrum she threw one day, ten minutes prior to the end of the session. Cassie glared at the counselor, stated "I'm leaving now," and turned toward the door. This was unusual for Cassie, but due to the fact that she was going through the Regressive Stage, Cassie pretended to be younger than she was and acted out with tantrum-like behavior.

Cassie exhibited signs of being in the Mastery Stage when after her tantrum of wanting to leave the play therapy room before her time was up, she took on responsibility of what was happening in the play therapy room, especially to the puppet she named "The Scary Guy." Cassie put on a police officer hat, which gave her the confidence she needed to slam blocks on top of the box that she had placed "The Scary Guy" in, and then covered the top of the box with a pile of blocks. Through her actions, it was clear that Cassie felt like the hero in not only her own life, but also in the play therapy room, since after covering the box with blocks she announced "Now we are safe!"

As evidenced from this one case study example, Guerney's (2001) four stages can be used to orient the counseling process and sets of cluster behaviors allow the counselor to tap into a child's experience.

Implications and Recommendations for Counselors

Drawing from the literature offered, it is evident that infusing play into the counseling process can be beneficial in helping children communicate their distress in a manner that is discernible to the counselor. The use of play within the counseling process allows for naturalistic expression of thoughts, feelings, and behavioral manifestations within the context of a counseling relationship. The major implication of the literature reviewed is that work with children can be greatly enhanced when play is infused in the counseling process and is central to the work being done. The implication of the evidence provided is that the counselor must be proficient at facilitating meaningful play in the context of the counseling relationship. Having a clear sense that play is purposeful will help to enhance the richness of in-session interactions, and thus be more likely to bring about fruitful results.

Clearly, children, in response to trauma, will respond to their inner experience of what it means to live in a world that can, at times, be threatening and uncertain. Taken one step further, children in general respond to trauma differently than adults. It has also been established that children at different developmental stages within childhood will respond differently. This can be understood as differing expressions of the level of cognitive complexity with which children will process their traumatic experiences. The first implication for counselors is that when working with children, one must be well versed in the cognitive capacity and how events are likely to be processed at various ages across the years that span childhood and on into early adolescence. This is especially important when working with children in a play environment in that the counselor must be adept at accurately identifying a child's expression through a developmental lens. In a sense, the counselor who is infusing play in the counseling process is in a constant process of conducting a qualitative analysis of what the child is expressing. An accurate interpretation of in-session data can only be achieved if the counselor is well grounded in, and familiar with, the developmental nuances that will be expressed by children of different ages.

It is also important to discern the movement the child makes across the basic stages comprised within the counseling process and the nature of the cluster behaviors that a child is likely to exhibit during counseling. Doing so will help to ground the counselor in understanding where the child is at any point in time within the counseling process, and enable the counselor to adjust interactions and clinical response style as the child moves from one stage to the next. Having a clear understanding of the types of cluster behaviors one can expect, especially those that are more challenging to manage, can also help the counselor respond in a clinically appropriate manner over the full course of the counseling intervention.

Special care must be taken in setting up a clinically appropriate play space that will provide a child with a variety of stimuli. Counselors must recognize that their role is to facilitate movement through the various stages contained within the

counseling process. It is also important to be cognizant of children for whom services will be provided. Unless the counselor limits the age range of the children that will be seen, the toys and game activities provided in the play space must be appropriate for children across the developmental stages that encompass childhood and early adolescence. Having a wide array of play objects and game activities is necessary so that the child will have a reasonable number of options from which to choose to express inner thoughts and feeling in more concrete ways. The bottom line is that children must be supported in their individual expressions by being able to choose toys or enter into play activities that serve to meet the goal of play interventions.

It is important for counselors who wish to focus their practice on assisting children who have endured traumatic experiences, to obtain the proper education to better ensure their effectiveness. Children who are working through the aftermath of trauma offer special challenges. Counselors working with this population must be well prepared for the difficulties that may arise. This is especially true when a child is acting out in a manner that is consistent with the aggressive cluster of behaviors. Obtaining supervision from a senior practitioner who is well versed in this work will go a long way to help the counselor to be engaging, remain energized, and increase levels of effectiveness. Because the counseling relationship is the foundation of this work, a clinical supervisor can assist with helping the counselor to build and maintain a bond with the child, as well as recognize the problematic themes that get expressed by the child within that relationship. A clinical supervisor can also assist with processing the in-session content that can be emotionally taxing to even the most seasoned counselor. Counselors must maintain adequate self-care when working with traumatized children and guard against the pitfalls of compassion fatigue and occupational burnout.

Conclusion

It has been well established that when children suffer the impact of traumatic events, the resulting vectors of response are different than those expressed by adults. Children, by virtue of their developmental stage, are limited in their ability to express the thoughts and feelings that get constructed around the traumatic event. Incorporating play in the counseling process provides a special language with which children can give voice not only to their past experiences, but also to the inner turmoil that has resulted from the traumatic event. Through the use of play therapy, children are given the opportunity to process the traumatic event by facilitating movement across specific stages of the counseling process. Engaging children of trauma in this manner allows counselors to better understand the child and thus connect on a deeper level than would otherwise be impossible. Use of play within the counseling relationship is an effective intervention for children since it adheres to a child's uniqueness, and focuses on what can be done to benefit the individual child most in overcoming the effects of traumatic experiences.

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