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Richard Joseph Behun, Editor

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# The Journal of the Pennsylvania Counseling Association

Volume 14, Number 1, Spring, 2015

A Vocational Development Group Program for Men Living with HIV/AIDS in Suburban and Small City Areas <b>Paul A. Datti &amp; Elizabeth J. Jacob</b>	2
Mitigating the Challenges of the Helping Relationship through Clinical Supervision The Costs of Caring: <b>Eric W. Owens, Cheryl W. Neale-McFall, &amp; Jennifer M. Toby</b>	12
Developmental Disability, Sexuality, and Counseling: A Call for Action and Ecological Implications <b>Michele Lopez</b>	19
The Development and Evaluation of a Mental Health Training for Foster Parents <b>Michael T. Morrow, Brooke E. Garwood, Lisa M. Brutko, Christina A. Schneider, &amp; Jessica A. Cuttic</b>	28
What's New, What's the Same, and What Matters for Practicing Counselors The 2014 ACA Code of Ethics: <b>Charles J. Jacob, Gregory Roth, Brittany Cilento, &amp; Jessica Stoler</b>	39

# A Vocational Development Group Program for Men Living with HIV/AIDS in Suburban and Small City Areas

Paul A. Datti and Elizabeth J. Jacob

HIV/AIDS has a significant impact on the vocational development of those living with the disease, particularly with regard to unemployment; however, there are still few vocational programs aimed specifically toward the population, particularly outside of major metropolitan areas. This article describes a small-scale, structured, psycho-educational group program that assessed changes in vocational identities, occupational information levels, and perceived employment barriers for HIV-positive men in suburban and small city areas that was piloted in two group iterations. Results on standardized measures indicated favorable changes in vocational identity, occupational information, and perceived employment barriers for many participants. Most participants reported reductions in HIV-specific barriers to employment and increased knowledge of vocational information and services. Practical implications and recommendations for future programs and research are discussed.

*Keywords:* HIV, AIDS, employment, vocational rehabilitation

Human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS) is a condition that affects all genders, races, ethnicities, sexual orientations, and communities. While epidemiology and demographics of the disease shifted over the last 30 years to include more women (Centers for Disease Control [CDC], 2013), infection rates for men continue to rise. Men are disproportionately affected by HIV/AIDS, as the ratio of men to women with the disease is almost three to one (CDC, 2013). Men who have sex with men (MSM) are most affected, as this population makes up more than two thirds of all men living with HIV/AIDS and accounts for over half of new HIV/AIDS cases (CDC, 2013). Although men with HIV/AIDS are members of all communities, there are unique implications for men in suburban and small city areas, including a steady rise in AIDS diagnoses in these types of localities (CDC, 2014).

Introduction of highly active antiretroviral therapies in the 1990s led to improved medical treatment for people living with HIV/AIDS (PLWHA); however, employment issues continue to be a concern

(Conyers, 2011; Conyers & Datti, 2008). Like other potentially disabling conditions, HIV/AIDS has significant impact on unemployment and employment loss, with rates of unemployment for PLWHA often exceeding 50% (Dray-Spira et al., 2005; Worthington, O'Brien, Zack, Mckee, & Oliver, 2012). While there are several vocational programs for individuals with various disabilities (e.g., state-federal vocational rehabilitation [VR] services), there remain few HIV-specific programs and limited evidence of effects of vocational counseling for PLWHA (Conyers, 2004; Kohlenberg & Watts, 2003). Given this, further development and implementation of HIV-specific vocational programs is necessary to better address their unique vocational needs.

While many PLWHA are able to and interested in work, health and medication issues, stigma, and fear of losing cash (e.g., Supplemental Security Income [SSI], Social Security Disability Income [SSDI]) and health (e.g., Medicare, Medicaid) benefits are some common real and perceived barriers to employment for PLWHA in most areas (Conyers & Datti, 2008; Hergenrather,

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Rhodes, & Clark, 2006; Worthington et al., 2012). In addition to fewer job opportunities and limited availability of vocational services, those in suburban and small city areas tend to have further difficulties, including increased stigma associated with HIV/AIDS, more significant poverty, and inadequate public transportation (Heckman, Somlai, Peters, & Walker, 1998), making pursuit of employment potentially more difficult.

Although policy initiatives for enhancing vocational development of people with disabilities and employment services for PLWHA have become more abundant in recent past, there remains a limited number of programs and studies on the impact of HIV/AIDS and employment (Conyers, 2004; Conyers, 2011). Further, while PLWHA are often eligible for VR (Rehabilitation Services Administration [RSA], n.d.) and other services to assist with vocational development, they tend to be underserved in the vocational service arena (Datti & Conyers, 2010; Datti, Conyers, & Boomer, 2013). The few studies on PLWHA that address VR use, for example, indicate that use rates tend to be less than 30% (Datti et al., 2013). Much like individuals with other illnesses and disabilities, PLWHA are often in need of services to assist them with vocational development (Datti et al., 2013); however, many may either not know about or not consider these services as an option.

For those PLWHA who do access services, many of their unique issues related to employment may go unaddressed or are beyond the scope of competence of many vocational providers (Kohlenberg & Watts, 2003). Moreover, many may not feel comfortable disclosing their HIV status or seeking vocational services from agencies whose providers may not be familiar with HIV/AIDS (Conyers, 2004). PLWHA are often provided medical and other primary services in AIDS Service Organizations (ASOs), and may feel more comfortable receiving services from these types of organizations as opposed to others such as VR (Conyers, 2004; Datti et al., 2013). For the most part, however, ASOs do not have adequate funding or trained personnel to provide vocational services to clientele (Conyers & Datti, 2008; Worthington et al., 2012). PLWHA who are in need of vocational services, yet are uncomfortable with or unaware of services outside of ASOs, may have limited options for such assistance.

Moreover, large and small scale HIV-specific vocational programs tend to be found in large urban areas. A review of the United States Department of Labor's (2012) list of HIV/AIDS service providers that offer employment services shows that each is located in a major metropolitan area. Examples of large scale programs include Positive Resource Center's (PRC)

*Employment Services Program* in San Francisco (PRC, 2014) and Gay Men's Health Crisis (GMHC) *Moving Ahead Toward Career Horizons* program in New York City (2014). Smaller, independent group programs are sparse as well and also tend take place in major metropolitan areas. Examples include Hergenrather et al. (2006), *Windows to Work* program, and Hergenrather, Geishecker, Clark, and Rhodes' (2013) *Helping Overcome Problems Effectively (HOPE)* program, both in Washington, DC. Other similar programs serving a larger number of participants include Kohlenberg and Watts (2003) *Making a Plan (MAP)* program in San Francisco, Kielhofner et al. (2004) *Employment Outcomes Program* in Chicago, Escovitz and Donegan's (2005) *Kirk Employment Empowerment Project (KEEP)* in Philadelphia, and Bedell's (2008) *Multi-Tasking Systems (MTS)* program in New York City.

While the development and implementation of these and other programs is encouraging, there remains a limited number of programs targeting specific vocational needs of PLWHA, particularly in suburban and small city areas. Given this, the authors present a small-scale inexpensive, fairly easy to execute piloted program that can be implemented in a variety of settings. Information is presented here in order to assist counseling and related professionals and researchers in developing and implementing similar programs and studies.

## Program and Method

The program was designed to be a pilot for future programs. Pilot studies are important in formative evaluation of programs and include methods such as pre-testing, seeking feedback, and participant observation to originate data for use in determining appropriateness of program features and plausibility of further implementation (Green & Lewis, 1986; Windsor, Baranowski, Clark, & Cutter, 1984). Overall goals were to gain information, provide assistance, and evaluate the program. It is important to note that a main goal was not for participants to find jobs, but rather to inform, educate, and provide skills for use when or if they wished to pursue vocational endeavors. The program was developed based on past research in the field of HIV/AIDS and employment (e.g., Escovitz & Donegan, 2005; Glenn, Ford, Moore, & Hollar, 2003; Kohlenberg & Watts, 2003) and also served to address unique needs of suburban and small city men.

The program included structured, psycho-educational sessions and assessment of vocational identity, occupational information, and perceived employment barriers. It was hypothesized that participants would experience: (a) positive changes in

vocational identity, (b) increased knowledge occupational information, and (c) reductions in perceived barriers to work. These constructs, as measured in part by My Vocational Situation (MVS; see description below), are described as follows by Holland, Daiger, and Power (1980):

*Vocational identity.* Vocational identity means the possession of a clear and stable picture of one's goals, interests, personality, and talents. This characteristic leads to relatively untroubled decision-making and confidence in one's ability to make good decisions in the face of inevitable environmental ambiguities.

*Occupational information.* [This] category provides the client the opportunity to indicate a need for vocational information, most of which is available in printed [or Internet] form; the counselor can quickly direct the client to the appropriate materials.

*Barriers to employment.* The barriers category invites the client to indicate perceived external obstacles to a chosen occupational goal...[which] may enable the counselor to focus promptly on a significant problem area. (p. 1)

These constructs were targeted in an effort to assist participants in clarifying vocational outlooks and directions as each may be affected by HIV/AIDS status. Vocational identity formation, for example, is important in career development (Savickas, 1985), and can be affected by disabilities and illnesses like HIV/AIDS. Strauser, Lustig, and Uruc (2006) found that individuals with disabilities were more likely to experience lower levels of vocational identity and noted this finding was consistent with past research. Lack of occupational information is also common issue among people with disabilities (Yanchak, Lease, & Strauser, 2005), and perceived barriers tend to be obstacles to employment for many with disabilities and illnesses such as HIV as well (Enright, Conyers, & Szymanski, 1996). Those in suburban or small city areas may be subject to more significant barriers due to remote locales and limited access to jobs and services.

### Participants

Participants included two groups of six HIV-positive men from suburban and small city areas in the Northeast, who were recruited from two separate agencies serving PLWHA on two separate occasions. Needs assessments were sent out to ASO consumers and those who expressed interest were screened and invited to participate. The only criteria for inclusion were an HIV/AIDS diagnosis and being at least 18 years of age. In both instances, no women or transgender individuals expressed interest or were

available for the program. Of the total (N = 12) participants, five indicated they were HIV-positive and seven indicated they had AIDS. Ten were White (non-Latino) and two were African American. Four identified as heterosexual and eight identified as gay. Age range was 37-66 (Mean = 49.25). Two were employed, and the rest were not working at the time of program inceptions. All had worked at some point, and all were at least high school graduates. See Table 1 for demographics.

### Instrumentation

In addition to a demographic form (requesting information on race, ethnicity, age, gender identification, sexual orientation, residential locale, HIV/AIDS status, education, employment status, and income), the MVS was administered at the beginning and end of the programs. The MVS is a 20-item, hand-scored instrument that measures vocational identity, occupational information, and perceived barriers to employment (Holland et al., 1980). It is used in vocational planning with various clientele, including individuals with disabilities, in both individual and group settings (Holland et al., 1980; Strauser et al., 2006; Yanchak, et al., 2005). Eighteen true-false items make up the Vocational Identity subscale, with questions such as, "I am uncertain about occupations I could perform well." The Occupational Information subscale consists of four true/false responses to the item, "I need the following..." (e.g., "More information about employment opportunities"). The Barriers subscale consists of four true/false responses to the item, "I have the following difficulties..." (e.g., "I am uncertain about my ability to finish the necessary education or training"; Holland et al., 1980). In all cases, a higher score is favorable.

Construct validity was established through the initial scale development process. Small to moderate correlations in expected directions between subscales and age, education level, and vocational aspirations were obtained for a sample of 824 individuals in high school, college, and business (Holland et al., 1980). Internal consistency for adult men was high on the Vocational Identity and Occupational Information subscales (.89 and .79 respectively), but lower on the Barriers subscale (.45). Studies on those with disabilities showed similar consistency for the subscales. For example, in Strauser et al. (2006) study on individuals with disabilities and traumatic symptomology, an internal consistency estimate of .87 was found on the Vocational Identity subscale. Similarly, Yanchak et al. (2005) found an internal consistency of .82 in a study of individuals with cognitive and physical disabilities. Also, test-retest reliability for this scale has been shown to be

**Table 1**  
**Participant Demographics**

**Group 1**

Participant	HIV Status	Sexual Orient.	Race	Employment Status	Education Level
1	AIDS	Heterosexual	AA	Unemployed	Trade/Vocational
2	AIDS	Gay	W	Unemployed*	Two Year Degree
3	AIDS	Gay	W	Unemployed	Trade/Vocational
4	HIV+	Gay	W	Employed (FT)	Trade/Vocational
5	AIDS	Gay	W	Unemployed	Four Year Degree
6	HIV+	Gay	W	Employed (PT)	Graduate (current)

**Group 2**

1	AIDS	Gay	W	Unemployed	Some College
2	AIDS	Gay	W	Unemployed	Two Year Degree
3	AIDS	Heterosexual	W	Unemployed	Two Year Degree
4	HIV+	Heterosexual	W	Unemployed	Some College
5	HIV+	Heterosexual	AA	Unemployed	Some College
6	HIV+	Gay	W	Unemployed	Trade/Vocational

Note. AA = African American; W = White; FT = Full-time; PT = Part-time.

\*Group 1 Participant 2 obtained a job during the program but was unemployed at its inception.

moderately high (.75) for periods of one to three months (Lucas, 1999).

Lastly, participants responded to these open-ended questions (OEQs) at the beginning and end of the programs: (1) Considering your HIV status, what do you consider to be your main barriers regarding obtaining or maintaining work? (2) What assistance do you need in order to help overcome those barriers? and (3) What do you know about state-federal vocational rehabilitation services? Questions 1 and 2 were incorporated to augment the limited barrier measures on the MVS for this population. Question 3 was added to augment occupational information measures and because facilitators had interest in measuring VR knowledge levels for this population. In addition, the following OEQs were presented at programs' end to assist with evaluation from participants' perspectives: (4) What was helpful for you in the program? (5) What was not so helpful? and (6) What suggestions do you have to improve the program?

## Procedures

Eight weekly or bi-weekly (depending on weather and scheduling) group sessions occurred on both occasions. Validity of topics was based on past research and through consultation with leading experts in the field of HIV/AIDS and employment (see Table 2 for an outline of sessions). Facilitators were a Certified Rehabilitation Counselor (CRC) and a Licensed Professional Counselor (LPC) who volunteered their time (Group 2 was run solely by the CRC). For both groups, participants were advised that participation was voluntary, had no bearing on services, and that they could drop out at any time without consequence. Confidentiality and informed consent were reviewed, and all participants agreed to participate. Meals were provided in each meeting, and both program iterations were approved by a university Institutional Review Board. Facilitators were awarded a small university grant to provide the second iteration.

**Table 2**  
**Group Session Outline**

Session Number	Description
1	Program description, group norms, confidentiality, informed consent, pre-testing.
2	To work or not to work and why? <sup>1</sup> Potential benefits/pitfalls of working, real and perceived stigma/discrimination, disclosure <sup>2</sup> , reasonable accommodation <sup>3</sup> issues.
3	Overview of SSI/SSDI/Medicare/Medicaid, review of public benefits counseling <sup>4</sup> and VR services <sup>5</sup> .
4	Review of the impact of work on health, medication issues, self-care, stress, and disability management (e.g., what to do if you become too ill to work).
5	Review of members' job skills, experience, training, and interests; demonstration of employment exploration tools (e.g., O*Net vocational data) <sup>6</sup> .
6	Resume building, provision of job seeking and interviewing skills training <sup>7</sup> .
7	Revisit disclosure, accommodations, stigma/discrimination, and topics of interest.
8	Discussion on future planning, provision of follow up support information and referrals, post-testing, program summary, termination.

Note. SSI = Supplemental Security Income; SSDI = Social Security Disability Income; VR = Vocational Rehabilitation

<sup>1</sup> Material used from "Why Work?" by K Escovitz, 2004 <http://www.gmhc.org/health/treatment/ti/ti1803.htm#8>. Copyright 2004 by the Gay Men's Health Crisis.

<sup>2</sup> Material from "Disclosing HIV Status in Employment," by B. Kohlenberg, 2001, <http://www.ctaidscoalition.org/hwpc/article1.htm>.

<sup>3</sup> Material from "Asking for Accommodations Under the ADA" by B. Kohlenberg, 2001, [http://www.bkohlenberg.com/asking\\_for\\_accommodations.htm](http://www.bkohlenberg.com/asking_for_accommodations.htm). Copyright 2001 by Betty Kohlenberg, M.S., CRC, AVEE.

<sup>4</sup> Material from "Returning to Work and Keeping Medicare and Medicaid," and "HIV and Employment: A Return to Work Guide." The latter is copyright 2002 by the AIDS Law Project of Pennsylvania.

<sup>5</sup> Material from "Office of Vocational Rehabilitation: What is OVR?" by the Pennsylvania Department of Labor and Industry, 2001, <http://www.dli.state.pa.us/landi/cwp/view.asp?A=128&Q=61197>. Copyright 2001 by the Commonwealth of Pennsylvania.

<sup>6</sup> Information used from "Welcome to O\*NET Online" by U.S. Department of Labor, 2008/2012, <http://online.onetcenter.org/>.

<sup>7</sup> Material adapted from "Vocational Assessment Services, Inc: Rehabilitation Manual," by J. Todd and G. Hubbard, n.d.

## Results

While data did not allow for decisive statistical analysis, descriptive terms are provided for pretest and posttest scores on the MVS along with qualitative information with regards to themes from participant feedback and group facilitator observations. Formative evaluation, to assess short term impact and field test measurements and interventions, was conducted via quantitative and qualitative methods regarding the pretest-posttest design (Green & Lewis, 1986; Windsor et al., 1984) on changes in vocational identity, occupational information, and perceived barriers of participants on the MVS. In addition, facilitators identified, categorized, and connected themes presented by participants on OEQs and throughout the program using multiple review of documents and individual interpretation of findings. Process evaluation, to examine structure and process and to monitor procedures, was conducted via participant observation with facilitators involved in the process and taking notes during or shortly after activities (Heppner, Kivlighan, & Wampold, 1999). Facilitators monitored activities and performed analysis of program process on an ongoing basis, and solicited feedback from participants. Process variables included information presentation format (e.g., verbal, written, and internet), opportunities to hear others' experiences, and hands-on activities (e.g. resume writing, computer use).

### MVS

See Tables 3 for score changes on the Vocational Identity, Occupational Information, and Perceived Barriers scales, respectively. Note that Group 1, Participants 2 and 6 discontinued attending near the end of the program. Participant 2 obtained a job out of state and Participant 6 experienced an increased work and study load. Of the ten who completed both pre- and posttests, five indicated positive changes in vocational identity, eight indicated positive changes in occupational information, and four indicated decreases in barriers to employment.

### OEQs

For OEQ 1, the following barrier themes emerged at pretest: (a) obtaining/maintaining health insurance, (b) ability to function for entire workday, (c) having to hide HIV status, (d) needing time off due to health, (e) inability to cope with increased stress, (f) financial loss, (g) explaining employment gaps, (h) needing frequent bathroom breaks, and (i) working while in school. At posttest, only a, b, c, f, and h emerged again; however, one participant noted the additional barrier of "finding a specific job or work environment." For OEQ 2, the following themes emerged about assistance needed at pretest: (a) uncertain/not sure, (b) job resources, (c)

Table 3

**Changes in Vocational Identity, Occupational Information, and Perceived Barriers to Employment  
as Measured by the MVS**

Participant	Vocational Identity			Occupational Information			Employment Barriers		
	Pretest	Posttest	Change	Pretest	Posttest	Change	Pretest	Posttest	Change
Group 1									
1	4	3	-1	2	3	+1	1	1	0
2	17	N/A		4	N/A		4	N/A	
3	5	14	+9	1	4	+3	4	3	-1
4	5	10	+5	0	4	+4	0	2	+2
5	17	18	+1	1	4	+3	1	3	+2
6	9	NA		4	NA		4	N/A	
Group 2									
1	7	4	-3	0	3	+3	1	1	0
2	10	10	0	0	4	+4	2	3	+1
3	3	6	+3	0	3	+3	2	2	0
4	12	2	-10	2	1	-1	2	2	0
5	9	12	+3	1	2	+1	2	3	+1
6	16	14	-2	1	4	+3	4	4	0

*Note.* Score range for vocational identity is 1-18 with 18 is the highest and most favorable. Score range for occupational information and employment barriers is 1-4 with 4 being the highest and most favorable.

obtaining health insurance, (d) legal assistance, (e) venues for support, and (f) information on Medicare and Social Security. At posttest, only need (d) emerged again; however, one participant noted that more education about VR would help, one noted that counseling would help, and one noted that he needed “more faith.” For OEQ 3 (VR knowledge) at pretest, six participants responded they knew “nothing,” three responded they knew “very little,” and three indicated that they help people with educational and/or employment goals. At posttest, all participants reported VR knowledge, including about the services they provide and how to contact them.

A process variable reported as effective was information presentation and its formats (e.g., verbal, written, and internet). Participants advised they preferred provision of information from facilitators in all forms as opposed to generating/researching on their own. Most members actively took notes as information was provided. In response to OEQ 4 (What was helpful for you in the program?), a common theme included information provision, particularly about Social Security benefits and job resources. For example, one participant offered the following: “For years I thought I couldn’t return to work without losing my [SSDI]

checks. But now that I have the information, I found that not only can I go back to work and keep the benefits I need, but the procedure is pretty easy...I am starting my job next month.” In fact, all but one participant noted that the information on Social Security benefits was especially helpful. Further, another noted, “The tangible resources are excellent. I can use them now or in the future. I am the kind of person that likes to gather as much information as possible in case I ever need it.”

Another process reported as helpful during the program and at posttest was the opportunity to hear others’ experiences. During each group, participants were encouraged to share employment-related experiences. Many did so, and many stated during the program and at posttest that it was quite helpful. For example, one participant noted that it was helpful “being around other people like myself...it was like a support group.” The only thing noted as “not so helpful” in the program at posttest (OEQ 5) was the interviewing skills portion (reported by a participant planning self-employment). Also, one participant indicated that he believed the resume writing workshop needed to be longer. In terms of program improvement (OEQ 6), four participants noted no suggestions, one

suggested “more information on writing a [business] plan,” (reported by the participant planning self-employment), and two suggested guest speakers from VR and/or Social Security. Lastly, one participant suggested the program be longer, and two suggested providing actual job placement services.

## Discussion

The goal of this pilot program and study was to provide and evaluate a small-scale vocational program for PLWHA in suburban and small city areas, including measuring changes in vocational identity, occupational information, and perceived barriers to employment. Positive changes in these areas are believed to elicit better vocational outlooks and directions for this and related clientele. In addition, evaluation of such programs is important for the counseling and related fields to add to literature regarding vocational issues for PLWHA. Findings make contributions to better understanding vocational development needs of suburban and small city men with HIV/AIDS. In particular, it highlights that a closed, structured psycho-educational group program can have a positive impact on vocational identities, occupational information levels, and perceived barriers to employment for this population.

Facilitators hypothesized that the program would elicit positive changes in vocational identity, which was evident by increased posttest scores for all completers in Group 1. Interestingly, only half of Group 2's scores increased. While reductions for the two groups were nominal, participant 3's score reduced by ten points; however, that participant was in the midst of legal issues, as such it is possible that they affected his vocational outlook thereby affecting his vocational identity. For those who experienced an increase, it suggests they may have gained clearer and more stable pictures of their vocational interests and goals, and increased confidence in making good decisions in the face of ambiguities (Holland et al., 1980). These findings are reflective of and enhance those of similar programs and studies. For example, while not specifically measuring vocational identity, Kohlenberg and Watts' (2003) found that their cycled eight-week group program was effective in assisting their sample ( $N = 67$ ) with increasing knowledge of job skills, lowering anxiety, and reducing perceived need for career planning assistance. Similarly, Hergenrather et al. (2006) found that their nine-week program using Community-Based Participatory Research and Photovoice was helpful in assisting participants ( $N = 11$ ) to identify and develop personal action plans. Also, Hergenrather et al. (2013) found similar results using their *HOPE* intervention. Their seven-week group

program assisted seven African American gay men in developing goal-setting and problem-solving skills, health-promoting behaviors, and job seeking skills.

Results also support the hypothesis that participants would increase their knowledge of occupational information, including about VR. All program completers in Group 1 and all but two in Group 2 reported positive changes on the MVS. Specific negative-to-positive changes included the need for information on how to find a job in chosen careers and need for information about employment opportunities. More-favorable score changes for Group 1 may be related to the more suburban setting as compared to Group 2. That is, they may have started with lower levels of occupational information, thus perhaps increasing their knowledge more significantly. In terms of VR, most participants gained knowledge about these services as a result of the program. At the beginning of the program, only one participant in Group 1 and two in Group 2 reported any specific knowledge of VR; however, in the end, all participants reported knowledge. Pretest findings are similar to those of other studies encompassing PLWHA and use of VR services (e.g., Conyers & Datti, 2008, Datti & Conyers, 2010; Hergenrather Rhodes, & Clark, 2004). Posttest findings have important implications for participants' future use of these services, which are geared toward assisting individuals with disabilities to obtain and maintain employment. In fact, three participants reported intent to pursue VR services at the end of the group, and the participant who was already enrolled advised he would continue with his services.

Regarding perceived barriers as measured by the MVS, of those completing the program, four reported a reduction (two in each group) and five reported no change. In addition, many initially listed HIV-specific barriers did not re-emerge at posttest. Participants did not note time off due health, inability to cope with stress, explaining work gaps, or frequent bathroom breaks as barriers; thus suggesting that information provided about disability management, resume and interviewing skills, and reasonable accommodation may have helped to alleviate some of these concerns. These results again reflect Kohlenberg and Watts (2003), who found that their program was associated with positive changes in perception of employment barriers. In addition, using a pretest-posttest design, Bedell (2008) found a significant improvement in participants' ( $N = 53$ ) perceptions of their ability to work, as well as increases with perceived ability to balance health, work, and daily life. Further, at posttest, participants did not report that obtaining health insurance, needing job resources, having venues for support, or having information on Medicare and Social Security were needed for overcoming barriers; thus suggesting that provision of information on these topics may have been

helpful in addressing such barriers.

Qualitative observations, analysis of program processes, and participant feedback supported the positive effects and evaluation of the program. This information is beneficial for practitioners and researchers of future similar programs who may want to consider such programs in efforts to assist clientele. Results also indicate that the program can elicit progress toward obtaining vocational goals, as some participants moved forward with vocational planning. In addition to those pursuing VR, two participants signed up for Social Security benefits counseling to determine how return-to-work may affect their benefits and one participant located and obtained a job during the program.

### Limitations

Caution should be exercised when considering these findings especially in the broader context of HIV/AIDS and employment programs and research. External validity is limited since they are based on a small sample of men with HIV/AIDS from suburban and small city areas, and data was not extensive enough to allow for decisive statistical analysis. The sample does not include those from major urban areas and does not represent the current demographics of men with HIV/AIDS. Also, participants were identified through agencies and expressed interest in the program; thus the sample was one of convenience. While convenience samples can provide useful information, especially for pilot studies (Simon, 2002), many demographics were not represented, including women, transgender individuals, and Latinos, each of which is becoming increasingly affected by the disease (Baral, Poteat, Stromdahl, Guadamuz, & Beyrer, 2013; Conyers & Datti, 2008; Datti et al., 2013). Regarding instrumentation, while the MVS is an appropriate instrument for measuring vocational identity, occupational information, and perceived barriers for several groups, including individuals with disabilities (Strauser et al., 2006; Yanchak, et al., 2005), the instrument does not directly address HIV-related employment barriers. Although participants in our program were asked to provide HIV-specific barriers via OEQs, those expressed may not be objectively valid and were not measured psychometrically. Further, we used self-report only, including on HIV-related barriers, knowledge of VR, and evaluation of the program. While self-reported information pertaining to the first two topics was supported by other studies (e.g., Datti et al., 2012; Hergenrather et al., 2004; Kohlenberg & Watts, 2003) and the latter supported by direct observation by the investigators, the information reflected issues as reported by the participants only and involved no other forms of measure.

### Implications for Practice

This program and study featured a population in which vocational development needs tend to go under-addressed. This is in part due to limited vocational service provision in HIV/AIDS community agencies. Because of the possibility of increased comfort in these environments and that stigma about HIV/AIDS may be higher in suburban and small city areas, increased provision of vocational services in such agencies and areas could be beneficial to assist many more individuals. Limited funding for these services in legislation (Conyers, 2011; Conyers & Datti, 2008) is a major deterrent for many agencies. Continuing to conduct and document programs such as the one described here may foster advocacy for more programs in community agencies and result in more funding for these needed services. In light of the recently implemented National HIV/AIDS Strategy, which has some focus on employment issues for PLWHA (Conyers & Boomer, 2014), the time is ripe to continue advocacy efforts to increase these needed services for a population who has historically been underserved (Datti et al., 2013).

Further, since ASOs and other agency staff are may be ill-equipped to handle HIV-positive clients' vocational needs, these organizations may benefit from guidance with services (Conyers, 2004; Kohlenberg & Watts, 2003). For this program's first iteration, the primary investigator provided qualified staff with comprehensive training and prepared a program manual for the agency for program repetition as needed. This can prove to be a cost-effective practice for integrating vocational services into ASOs and other agencies. While in this instance the primary facilitator was a CRC who volunteered time, other qualified CRCs or vocational professionals may be willing to do the same as part of pro-bono service endeavors or at affordable fees. Other possibilities include working with local universities with counseling and related programs that may have qualified faculty members willing to provide these services or to coordinate such experiences for their graduate interns or practicum students.

In addition, VR services can be a viable option for many PLWHA in need of vocational services (Conyers & Datti, 2008, Datti et al., 2013; Hergenrather et al., 2004). They tend to increase chances of successful employment for those who are eligible and use the services (Hayward & Schmidt-Davis, 2003), and can play an important role in health and prevention strategies for PLWHA (Conyers & Boomer, 2014). Similar to other studies, however, few participants had knowledge about these services. It is possible that limited outreach is a factor related to limited awareness by many PLWHA in general, which may be even more problematic for those in suburban and small city areas.

Increased provision of outreach and information to those in these areas seems warranted. Conyers and Datti (2008) suggest that VR professionals reach out to ASOs and related agencies and develop networks for clients to obtain information and access VR, and Misrok (2014) suggests that ASOs reach out to VR agencies to provide trainings on HIV-specific issues. These seem like viable and low cost ways of increasing knowledge of VR services for ASOs and vice-versa.

### Future Research

Repetition of this program and study, including with a larger sample may be helpful. Although the program is meant to be delivered in a small group counseling format, which does not allow for many participants at once, it may be beneficial to offer the program on a continuous basis while collecting data with each installment. Kohlenberg and Watts (2003) did this with their MAP program, serving 67 PLWHA and collecting data in several inceptions over a period of 15 months, as did Bedell (2008), whose program served 53 PLWHA over the course of two years in several iterations. This practice not only allows for a larger statistical sample, but also may allow for a more representative sample of PLWHA while at the same time providing needed services. Also, it is recommended that this program and study be repeated to include a cost-benefit analysis in terms of its long-term usefulness. By determining on a larger scale how benefits of programs may outweigh costs of execution, practitioners and researchers may be in a better position to advocate for more programs geared toward vocational needs of PLWHA. With this practice, practitioners and researchers can determine, on a more macro level, individuals' employment statuses, health conditions, and levels of use of SSI or SSDI, as well as further determine changes in vocational identity, occupational information, and perceived barriers after an extended period of time following programs completion.

### References

Baral, S. D., Poteat, T., Stromdahl, S., Guadamuz, T. E., & Beyrer, C. (2013). Worldwide burden of HIV in transgender women: A systematic review and meta-analysis. *The Lancet: Infectious Diseases*, 13(3), 214-222. [http://dx.doi.org/10.1016/S1473-3099\(12\)70315-8](http://dx.doi.org/10.1016/S1473-3099(12)70315-8).

Bedell, G. (2008). Balancing health, work, and daily life: Design and evaluation of a pilot intervention for persons with HIV/AIDS. *Work: A Journal of Prevention, Assessment, and Rehabilitation*, 31(2), 131-144.

Centers for Disease Control and Prevention. (2013). *HIV/AIDS surveillance report: Diagnosis of HIV infection and AIDS in the United States, 2010, 22*. Retrieved from [http://www.cdc.gov/hiv/pdf/statistics\\_surveillance\\_report\\_vol\\_22.pdf](http://www.cdc.gov/hiv/pdf/statistics_surveillance_report_vol_22.pdf).

Centers for Disease Control and Prevention. (2014). *HIV/AIDS surveillance in urban and nonurban areas*. Retrieved from [http://www.cdc.gov/hiv/pdf/statistics\\_surveillance\\_urban-nonurban.pdf](http://www.cdc.gov/hiv/pdf/statistics_surveillance_urban-nonurban.pdf).

Conyers, L. M. (2004). The impact of vocational services and employment on people with HIV/AIDS. *Work: A Journal of Prevention, Assessment, and Rehabilitation*, 23, 205-214.

Conyers, L. M. (2011). Overview of the national working positive coalition employment needs survey. HIV/AIDS employment roundtable proceedings (Ed.). Washington, D.C.: U.S. Department of Labor, Appendix C. Retrieved from <http://www.dol.gov/odep/pdf/20110408.pdf>.

Conyers, L. M., & Boomer, K. B. (2014). Examining the role of vocational rehabilitation on access to care and public health outcomes for people living with HIV/AIDS. *Disability and Rehabilitation*, 36(14), 1203-1210. <http://dx.doi.org/10.3109/09638288.2013.837968>

Conyers, L. M., & Datti, P. A. (2008). The unmet vocational rehabilitation needs of women with HIV. *Work: A Journal of Prevention, Assessment, and Rehabilitation*, 31, 277-290.

Datti, P. A., & Conyers, L. M. (2010). Application of the Behavioral Model of Service Utilization to predicting factors associated with VR use among a sample of Latino men with HIV/AIDS in New York State. *Journal of Vocational Rehabilitation*, 33, 1-11.

Datti, P. A., Conyers, L. M., & Boomer, K. B. (2013). Factors affecting VR use among Latino men with HIV/AIDS: A national perspective. *Journal of Applied Rehabilitation Counseling*, 44(3), 42-50.

Dray-Spira, R., Persoz, A., Boufassa, F., Gueguen, A., Lert, F., Allegre, T., Goujard, C., & Meyer, L. (2005). Employment loss following HIV infection in the era of highly active antiretroviral therapies. *European Journal of Public Health*, 16, 8995. <http://dx.doi.org/10.1093/eurpub/cki153>

Enright, M. S., Conyers, L. M., & Szymanski, E. M. (1996). Career and career-related educational concerns of college students with disabilities. *Journal of Counseling and Development*, 75, 103-114. <http://dx.doi.org/10.1002/j.1556-6676.1996.tb02320.x>

Escovitz, K., & Donegan, K. (2005). Providing effective employment supports for persons living with HIV: The KEEP project. *Journal of Vocational Rehabilitation*, 22, 105-114.

- Glenn, M. K., Ford, J. A., Moore, D., & Hollar, D. (2003). Employment issues as related by individuals living with HIV or AIDS. *Journal of Rehabilitation, 69*, 30-36.
- Gay Men's Health Crisis. (2014). *Workforce development program*. Retrieved from <http://www.gmhc.org/getsupport/stay-healthy/workforce-developmentprogram-8>.
- Green, L., & Lewis, F. (1986). *Measurement and evaluation in health education and health promotion*. Palo Alto, CA: Mayfield.
- Hayward, B. J., & Schmidt-Davis, H. (2003). *Longitudinal study of the vocational rehabilitation services program: Final report 2: VR services and outcomes*. Rehabilitation Services Administration: U.S. Department of Education. (ED Contract No. HR92022001). Retrieved from <http://www2.ed.gov/rschstat/eval/rehab/vr-final-report-2.pdf>.
- Heckman, T. G., Somlai, A. M., Peters, J., & Walker, J. (1998). Barriers to care among persons living with HIV/AIDS in urban and rural areas. *AIDS Care, 10*, 365-75. <http://dx.doi.org/10.1080/713612410>
- Hepner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in counseling (2<sup>nd</sup> Ed)*. Belmont, CA: Wadsworth.
- Hergenrather, K. C., Rhodes, S., & Clark, G. (2004). Employment-seeking behavior of persons with HIV/AIDS: A theory-based approach. *Journal of Rehabilitation, 70*, 22-32.
- Hergenrather, K. C., Rhodes, S. D., & Clark, G. (2006). Windows to work: exploring employment-seeking behaviors of persons with HIV/AIDS through photovoice. *AIDS Education and Prevention, 18*(3), 243-58. <http://dx.doi.org/10.1521/aeap.2006.18.3.243>
- Hergenrather, K. C., Geishecker, S., Clark, G., & Rhodes, S. D. (2013). A pilot test of the HOPE intervention to explore employment and mental health among African American gay men living with HIV/AIDS: Results from a CBPR study. *AIDS Education and Prevention, 25*(5), 405-22. <http://dx.doi.org/10.1521/aeap.2013.25.5.405>
- Holland, J. L., Daiger, D. C., & Power, P. G. (1980). *My vocational situation: Description of an experimental diagnostic form for the selection of vocational assistance*. Mountain View, CA: CCP.
- Kielhofner, G., Bravemen, B., Fianlayson, M., Paul-Ward, A., Goldbaum, L., & Goldstein, K. (2004). Outcomes of a vocational program for persons with AIDS. *American Journal of Occupational Therapy, 58*(1), 64-72. <http://dx.doi.org/10.5014/ajot.58.1.64>
- Kohlenberg, B., & Watts, M. W. (2003). Considering work for people living with HIV/AIDS: Evaluation of a group employment counselling program. *Journal of Rehabilitation, 69*, 22-29.
- Lucas, M. S. (1999). Adult career changers: A developmental context. *Journal of Employment Counseling, 36*, 115-118. <http://dx.doi.org/10.1002/fj.2161-1920.1999.tb01013.x>
- Misrok, M. (2014). *Expanding access to employment for people living with HIV*. Retrieved from <http://www.workingpositive.net/pdf/pf2014-misrok.pdf>.
- Positive Resource Center. (2014). *Employment overview*. Retrieved from <http://www.positiveresource.org/EmploymentOverview.aspx>.
- Rehabilitation Services Administration. (n.d.). *Vocational rehabilitation state offices*. Retrieved From <http://www.jan.wvu.edu/SBSES/VOCREHA.B.HTM>.
- Savickas, M. L. (1985). Identity in vocational development. *Journal of Vocational Behavior, 27*, 329-337. <http://dx.doi.org/10.1002/cd.23219853004>
- Simon, S. (2002). *What is a convenience sample?* Retrieved from <http://www.childrens-mercy.org/stats/definitions/convenience.htm>.
- Strauser, D. R., Lustig, D. C., & Uruk, A. C. (2006). Examining the moderating affect of disability status on the relationship between trauma symptomatology and select career variables. *Rehabilitation Counseling Bulletin, 49*, 90-101. <http://dx.doi.org/10.1177/00343552060490021001>
- U. S. Department of Labor (2012). *Employment and living with HIV: A resource guide*. Retrieved from <http://www.dol.gov/odep/topics/hivaids/EmploymentLivingwithHIVAIDS.pdf>.
- Windsor, R., Baranowski, T., Clark, N., & Cutter, G. (1984). *Evaluation of health promotion and education programs*. Palo Alto, CA: Mayfield Publishing.
- Worthington, C., O'Brien, K., Zack, E., Mckee, E., & Oliver, B. (2012). Enhancing labor force participation for people living with HIV: A multi-perspective summary of the research evidence. *AIDS and Behavior, 16*(1), 231-43. <http://dx.doi.org/10.1007/s10461-011-9986-y>
- Yanchak, K. V., Lease, S. H., & Strauser, D. R. (2005). Relation of disability type and career thoughts to vocational identity. *Rehabilitation Counseling Bulletin, 48*, 130-138. <http://dx.doi.org/10.1177/00343552050480030101>

# The Costs of Caring: Mitigating the Challenges of the Helping Relationship through Clinical Supervision

Eric W. Owens, Cheryl W. Neale-McFall, and Jennifer M. Toby

The professional counselor's work is demanding and the stressors can take a toll on the helper, personally and professionally. The purpose of this review was to examine the continuum of undesirable outcomes that can occur, as well as how to mitigate risks through clinical supervision. Supervision was viewed through the lens of Bronfenbrenner's (1979, 2005) concept of protective factors. Literature on alleviating negative counselor outcomes was examined and implications of the review were provided.

*Keywords:* Burnout, secondary traumatic stress, vicarious trauma, protective factors, clinical supervision

The work of a professional counselor is never easy. A counselor must actively listen to a client's presentation while assessing functioning, interpreting meaning, evaluating body language, conceptualizing the client's real concerns, developing a diagnosis, processing data through a theoretical framework, and developing a strategy for intervention. All of this is done while responding with intentionality, empathy, genuineness, and unconditional positive regard.

The responsibilities of a professional counselor extend beyond simply knowledge and skills to include being authentic and connected to one's clients. In doing so, the goal is to be empathetic; however, the inherent risk in this process is that empathy can turn to sympathy, and the helper can become immersed in the client's material and may take on the clients' problems as one's own. Professional counselors risk becoming enmeshed with clients while losing clinical perspective and objectivity.

The purpose of this analysis is two-fold in examining the various risks inherent in the counseling relationship, or what Figley (1995) calls the "cost of caring" (p. 10). First, this review will examine the continuum of the costs of caring as those risks relate to the field of professional counseling. Second, this examination will focus on how these dangers may be mitigated through clinical supervision, which benefits the helper and the client through objective, third party

evaluation of the counseling relationship and the functioning of the counselor.

## The Costs of Caring: The Inherent Challenge of Helping Others

The very essence of counseling suggests the notion of a *helping* relationship; that is, the relationship is between one who helps and one who is in need of help. Much of the literature in the helping professions understandably focuses on the client. However, less attention has been paid to the other participant in this relationship, the counselor. While a number of terms have been used to describe the impact of counseling on the helper, no universally accepted term for this phenomenon has emerged (Stamm, 1997). This is likely a result of the many different effects counseling can have on the counselor. These impacts can be viewed on a continuum, from less severe to significant and damaging to both the counselor and the counseling relationship.

An example of a less significant impact of the helping relationship on the counselor dates back to the origins of the profession and Freud's concept of countertransference (1910). In this conceptualization of the helping relationship, it was common and necessary for clients to project their thoughts, feelings, and desires

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on to the therapist, a process Freud (1910) described as transference. Countertransference, then, is the yang to the yin of transference; countertransference occurs when the therapist projects his or her beliefs, attitudes, and feelings on to the client. Freud never fully developed the concept of countertransference, but asserted it was a negative response to the client and was detrimental to the success of the therapeutic relationship (Gorkin, 1987). However, countertransference is also a natural consequence of the development of empathy and a working alliance between helper and helpee (Wilson & Lindy, 1994). Countertransference is assumed to be the result of unresolved conflicts within the counselor's own life, and that resolution of those conflicts is essential to becoming a fully functioning therapist (Gorkin, 1987).

Burnout represents a more significant influence on both the helper and the helping relationship. Freudenberger (1974, 1975) is often credited with introducing the term burnout to describe a consequence of human service work, specifically in the career counseling process. Freudenberger and Richelson (1980) defined burnout as the process of attempting to meet unrealistic, self-imposed goals, the result of which exhausts the helper's emotional, psychological, and physical resources. Maslach (1982) further defined burnout as a relationship between an individual and the environment. Specifically, Maslach (1982) explained burnout as process that affects those who help others and is comprised of three elements: emotional exhaustion, depersonalization, and reduced personal accomplishment.

Using this definition, burnout can be seen as an emotional response to the powerful and unrelenting strain of working closely with others, especially those who are severely distressed or have a multitude of life stressors (Maslach, 1982). The definition has three critical components: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion is characterized by the belief that the counselor's affective resources are consumed and the helper has nothing left to give others (Maslach, Jackson, & Leiter, 1996). Depersonalization is the cyclical development of negative attitudes about clients, or "viewing other people through rust-colored glasses-developing a poor opinion of them, expecting the worst from them, and even actively disliking them" (Maslach, 1982, p. 4). Finally, reduced personal accomplishment is defined as a negative self-evaluation, particularly in regard to the counseling relationship (Maslach et al., 1996).

Burnout is cumulative, that is, it typically manifests

initially with mild symptoms that increase in severity if left unchecked (Gentry, Baranowsky, & Dunning, 2002; Maslach, 1982). Burnout typically results from feelings of powerlessness, frustration, and inadequacy in meeting goals and can manifest itself through physical and emotional symptoms such as: sleeplessness, nightmares, headaches, back and neck pain, physical exhaustion, repeated illnesses, irritability, emotional exhaustion, and aggressive behavior (Maslach, 1982; McMullen & Krantz, 1988). It can result from intense work stressors, pressures from supervisors or subordinates, or misunderstandings among co-workers (Valent, 2002).

A more serious impact of counseling on the helper derives in the form of Secondary Traumatic Stress. Figley (1995) originated the term *compassion fatigue*, to describe the posttraumatic stress-related symptoms that may emerge among those who learn about trauma secondhand; Figley (1995) later redefined this phenomenon as Secondary Traumatic Stress Disorder (STSD). STSD is defined as the natural behaviors and emotions that result from knowing about a traumatic event experienced by a significant other; it's the stress that results from helping, or wanting to help, a traumatized person (Figley, 1995). Figley (1999) suggested that STSD symptoms often mirror those of Posttraumatic Stress Disorder (PTSD) and can include re-experiencing the traumatic event vicariously as described by the survivor of the trauma.

Figley (1998) suggests that any number of people can suffer from STSD. Family and friends of a traumatized person may experience STSD, as can helping professionals. For Figley (1998), one must be empathically involved with the traumatized person in order to be susceptible to STSD. Research on STSD has suggested that individuals who work with survivors of trauma often experience similar symptoms to those whom they help (Beaton & Murphy, 1995; Figley, 1995, 1999; Hyatt-Burkhart, 2011; Owens, 2011; Wilson & Lindy, 1994). These symptoms can include sleep disturbances, flashbacks, nightmares, anxiety, avoidance, and hyperarousal (Figley, 1999).

The last and most severe type of disturbance counselors face in their roles as helpers results in the form of vicarious traumatization. Vicarious trauma has been explained as a transformation in a trauma worker's core sense of self, resulting from empathic immersion with the survivor's traumatic experience (Perlman & Saakvitne, 1995). Vicarious traumatization is cumulative and permanent and will manifest itself in both the helper's personal and professional lives (Perlman & Saakvitne, 1995). Vicarious trauma

involves a profound change in the helper's core sense of self. (Pearlman & Saakvitne, 1995). These changes can cause a disruption in one's identity and worldview, the ability to manage emotions, to maintain positive self-esteem, to connect to others, in spirituality, and in existential worldviews.

Vicarious traumatization can also have an impact on the helper's basic needs and mental schema about issues such as safety, self-esteem, trust, dependency, control, and intimacy (Pearlman & Saakvitne, 1995). Individuals suffering from vicarious traumatization are also vulnerable to intense images and other PTSD symptomology. There are two factors that can impact a helper's susceptibility to vicarious traumatization: the nature of the therapy and its context, as well as the characteristics and vulnerabilities of the helper (Pearlman & Saakvitne, 1995).

Why, then, would these costs of caring be important to counselors and those in training? A professional counselor who is projecting on to a client, is burned out, or is experiencing STSD or vicarious traumatization, will not be functioning at the highest level possible. Decreased professional functioning can often have a negative influence on the counseling relationship, and may even reach the point of unethical behavior. The American Counseling Association ([ACA], 2014) *Code of Ethics*, specifically discusses issues of impairment and the importance of self-monitoring and monitoring colleagues for signs of "physical mental, or emotional problems" (p. 9) that may prevent the counselor from functioning effectively. Behavior such as depersonalizing clients or being triggered in to a trauma response by a client could certainly meet the level of impairment as indicated in the *ACA Code of Ethics*.

### Mitigating the Costs of Caring: Clinical Supervision

If the costs of caring are as significant as the literature suggests, how then can professional counselors mitigate these risks? This question can be examined through Bronfenbrenner's (1979, 2005) descriptions of risk and protective factors. Bronfenbrenner (1979, 2005) argued that risk factors are events in one's life that may potentially interrupt what would otherwise be normal human development. Conversely, protective factors are those things that can serve to defend a person from the potentially harmful influence of risk factors. The literature suggests that effective clinical supervision may serve as a protective

factor against the costs of caring described previously (Figley, 1995; Hyatt-Burkhart, 2011; Maslach, 1982; Owens, 2011; Pearlman & Saakvitne, 1995).

One of the key elements of counseling and counselor education is the process of supervision; supervision allows the supervisee to process client cases, receive effective feedback, and develop a professional identity. The development of a trusting and supportive supervisory relationship is essential in order for the supervisee to feel like a mutual participant in a safe, working alliance. The supervisory relationship has been identified as a key factor in a counselor's successful training and development (Menefee, 2007). There are a myriad of factors that comprise a successful supervisory relationship including: building compatibility and trust, creating a safe environment, and addressing expectations surrounding the role of the counselor. Skovholt and Ronnestad (2003) talk about seven stressors of the novice practitioner; two of the stressors most germane to this discussion include developing the proper balance of involvement in the counseling process as well as realistic goal-setting. Having a supportive supervisor can assist in striking that balance, as well as providing a forum for the novice counselor to reflect on the personal and professional impact that helping work can have on the trainee.

As supervision takes place and the supervisory relationship develops, the topics of wellness and burnout should be addressed. As described previously, burnout and poor self-care can lead to counselor impairment. It is critical that counselors-in-training learn about wellness and the risks of neglecting self-care (Roach & Young, 2007). There is a lack of research on trainee wellness, most notably issues related to how wellness develops or wanes throughout a student's journey in a counseling program. Additionally, there is a dearth of literature examining supervisors' focus on topics of self-care and burnout with trainees (Myers, Mobley, & Booth, 2003). Roach and Young (2007) address similar concerns, examining the role of counselor education programs' admissions criteria and gatekeeping processes related to student wellness. The lack of research in these areas indicates that even though there are known significant risks to both counselor and client, it is not clear if and how counselor educators are assessing, teaching, and guiding students when it comes to the costs of caring.

As the experienced professional in the relationship, a supervisor is responsible for being knowledgeable about the risks of the helping relationship, to teach their students about burnout and related concerns, and to

check in with how students are feeling as they progress through their training. Trainee burnout may begin as early as the practicum experience in the graduate program (Thompson, Frick, & Trice-Black, 2011). One possible reason for such early development of burnout is unrealistic goal-setting (Lambie, 2006; Thompson et al., 2011). Skovholt and Ronnestad (2003) describe these unrealistic goals as “glamorized expectations” (p. 53). Excessively high expectations may manifest in the belief that the new counselor will be able to help every client; this may result in an inability to balance both clients’ needs with the trainee’s stressors (Skovholt & Ronnestad, 2003; Thompson et al., 2011).

Another potential cause of burnout may be the disproportionate drive and excitement that counselors-in-training and new counselors usually possess (Wicks, 2012). Fitzpatrick and Wright (2005) describe this drive and excitement as a fire that may in turn lead to burnout; they write, “something cannot burn out if there was no fire” (para. 9). This sense of being on fire can often leave new counselors and students feeling disappointed when they are not able to complete every planned task or meet every unrealistic goal, despite how much time and effort was exerted (Lambie, 2006).

Counselor educators can help their students by reminding them of the importance of slowing down and setting realistic goals, which in turn can help trainees stay focused and enthusiastic, to “ensure there are always embers to keep the fire lit” (Wicks, 2012, p. 102). In a recent study, Thompson et al. (2011) examined trainees’ perceptions of self-care, burnout, and the supervision practices related to promoting counselor resilience. This study included 14 graduate students in a master’s program who were participating in practicum or internship coursework. A Consensual Qualitative Research (CQR) method was used and interviews focused on students’ experiences with supervision, burnout, and self-care (Thompson et al., 2011). The findings indicated that successful supervisors modeled appropriate self-care, talked about their own experiences with burnout, and encouraged their students to self-assess and become self-aware. Additionally, specific feedback and positive reinforcement from supervisors were indicated as possible protective factors for trainees. While this study examined burnout specifically, the same conclusions can be drawn for other costs of caring.

The study recommended a number of important factors to assist in mitigating the costs of caring. These included: (a) supervisors’ empathy for students, (b) the need to directly address the topics of burnout and self-care in more detail, (c) teaching students specific

methods of wellness and self-care, (d) providing detailed feedback about self-care, (e) providing information about coping strategies for stress, and (f) including specific lessons on how to manage an appropriate work-life balance (Thompson et al., 2011). Close to half of the participants reported that their supervisors were having conversations about these issues with them, specific to burnout and self-care. With the many potential risks facing the novice counselor, guidance, support, and modeling from one’s supervisor is essential during these beginning stages of training.

Concentrating on Thompson et al.’s (2011) notion of wellness as a mitigating factor, one method supervisors can use to help their trainees is through focusing on the trainee’s own stressors, while also guiding the trainee in the process of helping others (Lambie, 2006; Roach & Young, 2007). The purpose of this parallel process is to demonstrate to trainees that they cannot help others if they cannot help themselves. An isomorphic process exists between the two; if counselors are unable to mitigate the costs of caring, their ability to effectively help clients becomes impaired (Baker, 2003). The presence of a wellness model within a counselor education program may be one method of assisting counselors-in-training when learning how to address stressors, while positively influencing student development and building the resilience necessary to become an effective professional counselor and avoid the various costs of caring.

Roach and Young (2007) describe a wellness model that includes three critical elements: self-awareness, self-care, and personal development, which are also indicated as ethical responsibilities of professional counselors in the *ACA Code of Ethics* (ACA, 2014). With a focus on wellness within the counselor education curriculum, students have the opportunity to develop professional identity, self-awareness, and discuss professional demands. In turn, students in these programs have the potential to decrease their risk for burnout, secondary traumatic stress, and other forms of impairment.

In a study conducted by Roach and Young (2007), counseling students’ levels of wellness were assessed, comparing wellness levels for students who were in the beginning, middle, or end of their program. Two-hundred and four students attending CACREP accredited programs participated in this study and a five-level, higher order factor wellness model was used to measure the Creative Self, the Coping Self, the Social Self, the Essential Self, and the Physical Self (Roach & Young, 2007). Findings indicated that

although all the students scored higher on Total Wellness, no significant differences were found between the norm group and the experimental group on assessment of the Social Self, the Essential Self, or the Creative Self. It is important to note that there was a significant difference in Total Wellness by students who participated in a wellness course in their academic programs, although it accounted for a small portion of the variance.

While 48% of the students surveyed participated in an academic program that included a course on wellness, counselor education faculty are not clearly evaluating how this participation might impact student wellness (Roach & Young, 2007). The authors emphasize the need for research on how counselor education programs are including these topics into their programs and how students' wellness changes throughout their time in a counseling program. Without the direct supervision and evaluation from a supervisor, counselors-in-training may be at risk for developing an unhealthy work-life balance and may begin to view work as primary means of defining meaning in their lives.

Another potential cause of burnout can occur when trainees define themselves solely through their work as counselors; the results of doing so include unrealistic goal setting, which has been tied to counselor burnout (Skovholt & Ronnestad, 2003). To moderate this, Lambie (2006) developed a supervisory activity that is based on the importance of congruence between the counselor's personal and professional life. Lambie's (2006) subsequent research on the intervention has proven important in examining supervision as a protective factor for burnout prevention. This approach is grounded in humanism, one goal of which is developing congruence between the personal and professional selves. It is posited that this congruence then leads to higher levels of self-acceptance and a decrease in burnout risk.

The study used two supervision groups; one group included four participants with varying levels of professional experience, and the second group included nine participants that were all new counselors. In the sixth week of group supervision, members of the groups were given 20 minutes to write a personal meaningfulness statement, which was described to members as a "personal epitaph" (Lambie, 2006, p. 40). The participants were also asked to identify what causes them the most stress in their lives. Group members then reflected on the congruence between what they wrote in their personal statements and their identified stressors. The most common things that group members

identified as meaningful included: family, religion and spirituality, being a good partner and friend, and being a good person (Lambie, 2006). None of the participants identified work as something that was most meaningful to them. Similar stressors between the groups included: work, unrealistic expectations of their work, difficult clients, and work climate.

These findings directly reflect the incongruence that has the potential to cause burnout. Lambie (2006) writes, "This discussion launched a dialogue among the supervisees on how they were trying to achieve balance in their lives...it is interesting that all the supervisees stated that they had never thought about their life values in relation to their stress and happiness in this way" (p. 41). By reflecting on this self-reflection activity, participants were able to realize what is most important to them as compared to where their energy is being expended. The participants identified that the activity helped them to start trying to achieve congruence in their lives (Lambie, 2006). As a result, they were able to identify what gives life meaning as well as reflecting on how they can appropriately balance life meaning with the significance of being a successful counselor.

This study demonstrates how self-reflection in supervision can help counselors and counselors-in-training recognize incongruence. Ward and House (1998) also examined reflexive supervision, arguing that supervision should promote the development of a professional identity and self-awareness through reflection, rather than a singular focus on skill development. A reflective model of supervision may be particularly helpful to students by giving them an opportunity to work with their supervisors on processing broader professional issues. This comprehensive vision of supervision allows for more critical concerns to be addressed, such as how to prevent burnout and practice self-care.

Ward and House's (1998) model of problem-solving and reflective supervision includes four phases: Contextual Orientation, Establishing Trust, Conceptual Development, and Clinical Independence; according to the model the counselor-in-training moves through each of these four phases. Beginning with the Contextual Orientation phase, supervisors help their trainees confront the anxiousness and perfectionism that are common for new counselors, clarify anything that students may not be understanding in their skill development and/or classes, and teach students the importance of ethics. In the Establishing Trust phase, supervisors focus on building trusting relationships with their supervisees, which in turn encourages honest and open self-reflection. The third phase, Conceptual

Development, includes helping students turn their experiences in training into meaningful schemas, that is expanding their specific experiences as trainees in to larger, conceptual frameworks. Through self-reflection and building a trusting relationship with their supervisors, students are able to further develop as a counselor and reach the end goal of Clinical Independence. By reaching this last phase, the supervisee has become comfortable taking risks and is confident when defining a professional identity (Ward & House, 1998). This self-reflective model requires that supervisors help students learn from their training experiences; simultaneously, supervisors must create a trusting environment so that the student can move from seeing oneself as a trainee to a self-image of a capable and competent professional counselor.

It is clear from the literature that more research on the use of supervision to mitigate Figley's (1995) "cost of caring" (p. 10) is necessary. For example, issues of the wellness of counselors-in-training could be further explored, as could the infusion of wellness in to counselor education curricula. Additionally, more attention could be paid to issues of wellness and self-care in the supervisory relationship. Most importantly, a further quantitative study examining the relationship between the costs of caring and supervisory theories, styles, and interventions would be beneficial. As indicated previously, the counseling relationship may prove beneficial for the client, but can often come at a cost for the counselor. These costs can significantly impact the effectiveness of the counselor, and subsequently the outcomes for the client. Ensuring counselors are functioning effectively is not only an ethical imperative, it is also critical to the success of clients in the therapeutic process.

## References

- American Counseling Association (2014). *ACA Code of Ethics*. Alexandria, VA: Author.
- Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. Washington, DC, US: American Psychological Association.
- Beaton, R., & Murphy, S. A. (1995). Working people in crisis: Research implications. In C. R. Figley (Ed.). *Compassion Fatigue: Coping with secondary PTSD among those who treat the traumatized*. New York: Brunner Mazel.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.
- Bronfenbrenner, U. (2005). *Making human beings human*. Thousand Oaks, CA: Sage.
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). Bristol, PA: Brunner/Mazel.
- Figley, C. R. (1998). Burnout in families. In C. R. Figley (Ed.), *Burnout in families: The systematic costs of caring* (pp. 15-28). Boca Raton, FL: CRC Press.
- Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators* (2nd ed., pp. 3-28). Lutherville, MD: Sidran Press.
- Fitzpatrick, R. & Wright, C. (2005). Review of the Maslach Burnout Inventory. In R. A. Spies and B. S. Plake (Eds.), *The sixteenth mental measurements yearbook*. Retrieved from <http://www.ebscohost.com>
- Freud, S. (1910). The future prospects of psychoanalytic theory. *Standard Edition, 11*, 141-151. doi: 10.1037/e417472005-267
- Freudenberger, H. J. (1974). Staff burnout. *Journal of Social Issues, 30*, 159-165. doi: 10.1111/j.1540-4560.1974.tb00706.x
- Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. *Psychotherapy, Theory, Research and Practice, 12*, 73-82. doi: 10/1037/h0086411
- Freudenberger, H. J., & Richelson, G. (1980). *Burnout: The high cost of high achievement*. Garden City, NY: Anchor Press.
- Gentry, J. E., Baranowsky, A., & Dunning K. (2002). ARP: The accelerated recovery program (ARP) for Compassion Fatigue. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 123-138). New York: Brunner-Routledge.
- Gorkin, M. (1987). *The uses of countertransference*. Northvale, NJ: Jason Aronson.
- Hyatt-Burkhart, D. (2011). *The lived experience of mental health workers in a residential treatment facility who work with multiply traumatized children and self-identify as experiencing vicarious trauma and compassion satisfaction* (Doctoral dissertation). Retrieved from <http://digital.library.duq.edu/cdm-etd/>
- Lambie, G. W. (2006). Burnout prevention: A humanistic perspective and structured group supervision activity. *Journal of Humanistic Counseling, Education, and Development, 45*, 32-44. doi: 10.1002/j.2161-1939.2006.tb00003.x
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice-Hall.

- Maslach, C., Jackson S., Leiter, M. P. (1996). *Maslach Burnout Inventory* (3<sup>rd</sup> ed.). Palo Alto, CA: Consulting Psychologists Press.
- McMullen, M. B., & Krantz, M. (1988). Burnout in day care workers: The effects of learned helplessness and self-esteem. *Child and Youth Care Quarterly*, *17*, 275-280. doi: 10.1007/BF01083908
- Menefee, D. S. (2007). Perceptions of trainee attachment in the supervisory relationship (Doctoral dissertation). Retrieved from ProQuest. (Order No. 3272589).
- Myers, J. E., Mobley, A. K., & Booth, C. S. (2003). Wellness of counseling students: Practicing what we preach. *Counselor Education & Supervision*, *42*, 264-274. doi: 10.1002/j.1556-6978.2003.tb01818.x
- Owens, E. W. (2011). *The resident assistant as paraprofessional counselor and crisis interventionist: A study of lived experience* (Doctoral dissertation). Retrieved from <http://digital.library.duq.edu/cdm-etd/>
- Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150-177). New York: Brunner Mazel.
- Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education & Supervision*, *47*, 29-45. doi: 10.1002/j.1556-6978.2007.tb00036.x
- Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, *30*, 45-58. doi: 10.1023/A:1025125624919
- Stamm, B. H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly*, *8*, 1-3. doi: 10.1037/e572172010-002
- Thompson, E. H., Frick, M. H., Trice-Black, S. (2011). Counselor-in-training perceptions of supervision practices related to self-care and burnout. *The Professional Counselor*, *1*, 152-162. doi:10.15241/eht.1.3.152
- Valent, P. (2002). Diagnosis and treatment of helper stresses, traumas, and illnesses. In C. R. Figley (Ed.), *Treating compassion fatigue*. (pp. 17-37). New York: Brunner-Routledge.
- Ward, C. C., & House, R. M. (1998). Counseling supervision: A reflective model. *Counselor Education & Supervision*, *38*, 23-33. doi: 10.1002/j.1556.6978.1998.tb00554.x
- Wicks, R. J. (2012). *The inner life of the counselor* [electronic resource]. Retrieved from <http://site.ebrary.com/lib/westchester/reader.action?docID=10583400>
- Wilson, J. P., & Lindy, J. D. (1994). Empathic strain and countertransference. In J. P. Wilson & J. D. Lindy (Eds.), *Countertransference in the treatment of PTSD* (pp. 5-30). New York: The Guilford Press.

# Developmental Disability, Sexuality, and Counseling: A Call for Action and Ecological Implications

Michele Lopez

Despite significant efforts in changing the particular views that society holds about people with developmental disabilities, there had been only a few research attempts to understand the counselors' views and willingness to discuss and address sexuality issues in the work with these clients (Stinson, 2004). This article used Bronfenbrenner's ecological model (1979) to explore the intersection between sexuality and disability, and proposed action steps for advocacy and social change recommendations for counselors and counselor educators.

*Keywords:* Sexuality, developmental disability, ecological model, counselor education

Sexuality in people with developmental disabilities is a topic infrequently discussed in American culture or in the mental health field. The traditional societal views of sexuality involve youth and attractiveness, which tend to be inconsistent with the reality or stereotypes associated with people with developmental disabilities (Arokiasamy, Rubin, & Roessler, 2008). Constrained social perceptions of sexuality in developmental disabilities are manifested when affection, care, and love are rarely mentioned, being replaced by the emphasis given to capacity, techniques, risk, and dysfunction (Brodwin & Frederick, 2010). For example, psychological research focused on Lesbian, Gay, Bisexual and Transsexual (LGBT) individuals with disabilities tends to also be negative focused, concentrated in risky sexual behaviors and sexually transmitted diseases (Fralely, Mona, & Theodore, 2007). This manuscript presents an alternative ecological view of the counseling work with these persons.

Efforts from parents, care providers, advocates, and agencies have attempted to raise awareness of the importance of addressing issues of sexuality in the developmental disabilities field from a more humane and social justice perspective (Brodwin & Frederick, 2010). However, sexual education efforts and training for teachers and support staff have fallen short of

emphasizing knowledge, access, and choice as critical components in developing, maintaining, and supporting sexually related experiences in these individuals (Bernert, 2011; Stinson, 2004). Authors have emphasized the importance of individuals with developmental disabilities being afforded the opportunities for the development of sexual identity and its free expression. For instance, Bernert (2011) found that women with intellectual disabilities experienced institutional oppression that impacted their sexual identity development and sexual expression, creating feelings of inadequacy and fear around sexuality. Moreover, when persons with disabilities identify with non-heteronormative gender identities, they are the subject of double environmental barriers and even more negative societal views that impact the open expression of their sexuality (Ballan, Romanelli, & Harper, 2011; Fralely et al., 2007).

Educative efforts have at the same time lacked effectiveness in raising awareness and instilling knowledge and sensitivity about the intersection of these topics in residential staff and mental health practitioners, as these professionals are usually reluctant to have these conversations for a variety of personal and cultural reasons (Juergens, Miller, & Berven, 2009; Kazukauskas & Lam, 2010; Meaney-

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Tavares & Gavidia-Payne, 2012; Stinson, 2004). This has not only hindered the effectiveness and sensitivity of counselors' interventions, but has also further perpetuated oppressive views in the field. Therefore, the importance of developing a multidimensional view of sexuality in developmental disabilities and stressing the responsibility of mental health professionals for advocacy make necessary the elucidation of a valid set of practical implications for counselors and counselor educators. These implications are presented below.

## Developmental Disabilities

The word *disability* directly makes reference to the lack of capability (Garland-Thomson, 2012) that is evidenced as a result of a critical incident (e.g., illness, accident) or by normative descriptions of time (Kafer, 2013). Moreover, the term *disability* is an umbrella term that culturally implies the person's lack of the ability to care for themselves (Bernert, 2011) or to participate in typical activities due to a physical or mental dysfunction in the body (Ballan et al., 2011). Despite the vast multiplicity and complexity of the disabilities field, this article aims to contribute to the evident dearth of counseling literature in the specific realm of developmental disabilities by examining the intersection of disability and sexuality and offering implications for the Counselor Education field.

In the counseling field, the definitions of developmental disabilities have been historically attached to the medical model and have rooted their emphases on pathology, deficit, and disadvantage in individuals with disabling conditions (Pledger, 2003; Stinson, 2004). These definitions have stressed the need for the medical field to address the abnormality in these atypical bodies (Kafer, 2013). This pathologizing and normative view of disability reduces the human experience to a dichotomous reality where the person is able or not (Linton, 1998). Contemporary models conceptualize disability as a social, cultural, and political phenomenon, and place more emphasis on the environmental variables surrounding the individual and the person's fit to the environment's demands (Pledger, 2003).

In these latter models, the emphasis is placed in the complex interactions between the individual and the larger social and political world instead of being considered an inherent condition of the person. Specifically, the Minority Group Model of Disability recognizes these individuals as part of a marginalized group, vulnerable to the same bias and discrimination as any other group based on race, ethnicity, sexual orientation, or religion/spirituality (O'Brien, 2011).

Moreover, more contemporary paradigms of disability do not seek to fix the individual but to address the larger social and political context by re-constructing the view of disability in our society through interaction and discourse (Ashby, 2012). Taken further, this view of disability and its relation to sexuality also emerges and is reinforced in the interactions between individuals and mental health providers, placing the responsibility on counselors for awareness and advocacy, and highlighting the importance for counselors to understand and be competent in this regard.

## Societal Views and Myths of Sexuality

Because people with developmental disabilities often present cognitive and/or physical impairment, oppressive and stereotyped views of sexuality in this group have been prevalent from early civilizations to modern day (Arokiasamy et al., 2008). As a result of these negative views, myths surrounding sexuality and developmental disabilities have emerged and been maintained in the collective thinking, perpetuating inequalities and disenfranchisement in this minority group. Research shows that these myths affect not only the sexuality of people with developmental disabilities but also impact their self-esteem, the perception of their own bodies, and their motivation for independent living (Bernert, 2011; Brodwin & Frederick, 2010; Fraley et al., 2007).

The presence of cognitive impairment in adolescents and adults might perpetually foster child-like views of these individuals (Wolfe & Blanchett, 2000) who are, therefore, considered asexual (Brodwin & Frederick, 2010; Rivera, 2008). This misconception is reified through evaluations and support services decisions made according to the functional age of the individual. This practice seems to be institutionalized since psychological evaluations are based on measures such as the Vineland Adaptive Scale, which determines intellectual disability according to age-equivalent scores (Stinson, 2004) and potentially perpetuates beliefs that people with disabilities are not sexual beings or should not experience sexual desires.

Moreover, people with developmental disabilities might be considered over-sexed and as having uncontrollable urges (Stinson, 2004). Stinson (2004) describes society's mistaken expectation for individuals with developmental disabilities to know what is socially adequate, even when no formal or consistent sexual training is provided to these groups. The lack of an established and consistent concept of how to address sexuality issues might contribute to mental health and support systems (i.e., educational and residential settings) acting in consequence to sexual behaviors that

become problematic, instead of taking preventative steps to avoid potential issues and foster healthy sexuality (Stinson, Christian, & Dotson, 2002). For example, a myth about providing sexual information to these individuals suggests this information may act as a trigger to problematic sexual behaviors and sexual abuse. However, research has been conducted to understand the impact of providing sexual information to people with developmental disabilities, and findings indicate that sex education fosters positive changes such as increased appropriateness of sexual expression and more adequate social skills (Lumley & Scotti, 2001).

Along with the mistaken view that persons with developmental disabilities are paradoxically oversexualized and infantilized at the same time, it is often assumed that they lack the necessary social skills and judgment to effectively navigate their sexuality (Brodwin & Frederick, 2010). This is also understood as a lack of skills for adequate sexual expression, to engage in meaningful relationships, and to effectively parent. These views impact the way persons with developmental disabilities internalize social rules of sexual engagement, resulting in distorted notions of sexual expression.

Bernert and Ogletree (2013) conducted an ethnographic study with forty-eight women with intellectual disabilities and found that even though these women displayed some sense of self-determinism in their sexual behavior, they also held negative perceptions of sex resulting in self-imposed abstinence predicated by fear of intercourse, intimacy, or their outcomes. The authors concluded that these women experienced: fear, erratic behaviors, increased risks for abuse and sexually transmitted diseases, involuntary abstinence, marginalization, embarrassment, and hopelessness. The authors also found significant amounts of emotional pain resulting from these women's internalization of socially transmitted views of them as unable to experience intimacy, sexual pleasure, parenthood, and freely embrace diverse sexual orientations (Bernert & Ogletree, 2013). This study stressed the impactful nature of these women's experiences and reasserted the importance of the sensitive incorporation of these topics into counseling work and research as a way to foster development and wellness.

People who provide mental health services are not necessarily free from the subtle impact of these views and stereotypes, which will influence how support is provided to these individuals (Bernert, 2011). The stance adopted by mental health providers, and the extent to which these perceptions are maintained and reinforced, often depend on individual values regarding sexual expression and disability (Stinson et al., 2002). Topics such as positive sexual identity formation,

sexual pleasure, positive sexual self-identification, LGBT identification, and successful sexual relationships of individuals with disabilities have been largely overlooked within the discipline of psychology (Fraley et al., 2007; Schulz, 2009). Furthermore, despite the impact that these negative views have in counseling persons with disabilities, Counselor Education programs, with the exception of Rehabilitation Counseling programs, might not emphasize a focus in disability issues (Smart & Smart, 2006). In the past, this was explained by the low likelihood of encountering these individuals in helping settings. However, this reality has changed because of sociopolitical factors (i.e., the Americans With Disabilities Act, of 1990) and counselors are frequently faced with individuals with different kinds of disabilities or their families in a variety of settings. For instance, people with disabilities in higher education and employment settings might access counseling services to address the impact of natural stressors of these environments in their mental health such as anxiety, depression, and relationship issues (Smith, Foley, & Chaney, 2008). Thus, because of changing sociopolitical factors, counselors and training programs need to be competent in working with clients with disabilities.

## Difficult Conversations

In working with these individuals, counselors are required to evaluate their own biases and build awareness of their internalized stereotypical views to be able to understand the reality of sexual experiences in this group and its influence in their families (Ballan, 2012). For example, counselors need to be prepared to provide sensitive and unbiased help to individuals and their families concerned with sexuality, or individuals with disabilities transitioning through their coming out process (Ballan, 2012; Fraley et al., 2007; Ballan et al., 2011).

Furthermore, for counselors to be able to do this it is necessary that graduate programs focus on addressing the reactions of counselor trainees to having difficult conversations about ableism and other views that perpetuate oppression. In a study developed by Schulz (2009), findings suggest that psychology programs have focused on the impact that the disability has on the person's sexuality, and have emphasized theories about disability and sexual identity development. According to Schulz (2009), psychology programs have not focused on the helpers' reactions to these topics and their critical self-exploration, or on their ability to engage in these difficult conversations. Similarly, in the field of Counselor Education, including Rehabilitation Counseling, the need for efforts to study counselors' reactions and for the development of awareness and

sensitivity in this regard are also evident. Furthermore, the institutions that train these professionals might still maintain practices that reflect socially-embedded negative attitudes or beliefs about this marginalized group by not emphasizing such important aspects of the human experience, such as healthy sexuality (Stinson, 2004).

Watt et al. (2009) performed a study in a Counselor Education program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) at a large U.S. midwestern university. In this study, students submitted journals and reaction papers that reflected socially-embedded attitudes regarding those who are perceived as being different in terms of race, sexuality, ability, and so forth. The most relevant reactions to the topic presented in this article were benevolence and false envy, that is, understanding people with disabilities as brave, and even wishing to have a disability as an indicator of personal strength.

Furthermore, in the field of Rehabilitation Counseling, studies have explored the willingness of counselors to discuss sexuality with their clients (Juergens et al., 2009), and their comfort level in doing so (Kazukauskas & Lam, 2010). Juergens et al. (2009) found that the willingness of these counselors to have conversations related to sexuality with individuals with disabilities was directly impacted by the counselor's knowledge of sexuality and their own comfort level with the sexual aspects of the counselor's life. The authors suggest that counseling programs should include sexuality education in their curriculum as well as instructional and experiential activities that increase the comfort level in students, which will enhance their willingness to discuss sexuality with their clients in the future.

Counselors' comfort levels in discussing sexuality were specifically studied by Kazukauskas and Lam (2010). Results indicated that knowledge and attitudes towards people with disabilities directly contributed to their comfort levels in addressing sexuality with their clients. Along with Juergens et al. (2009), the implications from this study emphasize the need for increased sexuality and disability education and training in counseling programs.

If Counselor Education programs are to generate opportunities for training and sensitization in this topic, they will likely encounter students' reactions to difficult dialogues as those described by Watt et al. (2009). Therefore, programs need to prepare students to review potential unidentified paternalistic and ableist reactions in working with individuals with disabilities, to unpack the multilayered privilege in their different cultural identities, to create critical consciousness, and ultimately to understand social justice issues related to their dominant cultural identities. The awareness

resulting from engaging in difficult dialogues may foster counselors to move beyond ethnocentrism and able-centrism to a more honest, sensitive, and respectful interchange with others (Ballan et al., 2011; Watt et al., 2009).

## Advocacy and Social Change

Advocacy and social change have been considered growing forces in the counseling profession (Chang, Crethar, & Ratts, 2010) and a central competence identified by the American Counseling Association's (ACA) *Code of Ethics* (ACA, 2014). These actions have augmented the awareness of counseling students, who increasingly receive more training in advocacy skills throughout their programs of study. Moreover, the concept of social advocacy has been introduced in the literature to pinpoint counselors' responsibilities for working on behalf of clients to minimize oppression and discrimination (Chang et al., 2010; Glosoff & Durham, 2010) with the goal of obtaining fair, just, and equitable treatment or access to services (Chang, Hays, & Milliken, 2009). In preparing counselors for social justice in this regard, counselors-in-training need to acknowledge issues of privilege, power, intentional and unintentional oppressive views, and their intersectionality with other dimensions of the human experience.

Counseling programs and clinical supervisors have the responsibility to raise issues of diversity, power, and privilege with their supervisees (Hays & Chang, 2003), even though some of them may be reluctant to engage in these difficult dialogues. This reluctance reveals the need for instructional and experiential activities that help students think sensitively about the clients they serve, embrace diversity, and understand the multilayered nature of the counseling work (Bartoli, Morrow, Dozier, Mamolou & Gillem, 2014). Stinson (2004) used Bronfenbrenner's (1979) model to present and explain the interplay of systemic factors between social systems and the individual. This model's interplay is depicted in four different layers (see Figure 1) that use the analogy of nesting dolls with various levels of systems nested within each other. Bronfenbrenner's (1979) model is used and expanded in this article by incorporating advocacy and social change implications for counselors in all systemic levels.

## Ecological Review and Advocacy Recommendations

The individual is usually situated in a multisystemic reality described by Bronfenbrenner

(1979) where the person can be blamed for the surrounding social injustices (Stinson, 2004). People with developmental disabilities may exhibit frustration and anger through problematic behaviors or may engage in inappropriate sexual behaviors if they are not afforded knowledge and opportunities for healthier sexual options (Robinson, Conahan, & Brady, 1992). Consequently, these behaviors may reinforce negative beliefs and attitudes from the environment (Strickler, 2001), specifically with those closer to the individual, such as support staff, mental health providers and family. In return, individuals internalize those negative social messages and conform to oppressive social expectations by integrating values and assumptions that devalue their personhood based on their sexual identity (Ballan et al., 2011)

Counselors working with these individuals might need to address the individual's concerns by understanding the impact of social systems on their presenting problems. For this to happen, it is necessary that counseling programs prepare students to gain awareness about the various guidelines laid out by professional organizations (Fraleley et al., 2007), and to expand their understanding and views of people with disabilities through training and awareness building of their own negative views. The goal of these training programs is for counselors to be able to recognize the individual's presenting problems as indicators that respond to systemic or internalized oppression, to identify strengths and resources of the clients, and to advocate for their clients by empowering them. This empowerment may assist clients in identifying internalized barriers and gain access to the resources needed.

Bronfenbrenner (1979) defined the Microsystem level as the institutions and groups most intimately related to the individual. These interactions include peers, family members, friends, romantic partners, counselors, doctors, and support staff. For people with disabilities, family and support staff are likely to represent a highly-significant microsystem and main source of support (Goble, 1999). However, negative societal views of sexuality and disabilities have a multilevel impact, which can be perpetuated by staff, family, and mental health professionals as well, impacting the opportunities for knowledge, access, and choice for these individuals regarding their sexual experiences. Also, people with developmental disabilities might be in disempowered positions in their relationships, having to unquestionably follow directions from health providers, or having minimal power to enforce their preferences, opinions, and choices. This power differential confirms counselors' responsibility to gain awareness about power factors (i.e., knowledge, gender, race, class, etc.) as they advocate for clients.

Counselors working with these individuals need to involve different subsystems that are cultivating and maintaining oppressive views in individuals with disabilities' lives. It is important that counselors engage these persons and their families to understand the social dynamics and to strive for minimizing the effect of intentional and unintentional family messages on the sexuality of these individuals (Stinson et al., 2002). Counselors have the responsibility to advocate for the change of these views not only at the individual level but also at the micro level with their families, support staff, and other people involved in treatment and rehabilitation.

For example, counseling programs could intervene by strengthening the training in systems approaches to help the counselor articulate sessions involving the identified client, and also significant others that surround the individual. Moreover, according to Lewis, Arnold, House and Toporek (2003), counseling programs need to raise awareness about the importance of the development of students' advocacy competencies and other skills needed to identify barriers, develop alliances with subsystems, and negotiate relevant services and education systems on behalf of their clients. A potential example of this might be the active and intentional incorporation of advocacy competencies to be demonstrated in case presentations to foster systemic change at the micro level.

The Mesosystem level consists of the interactions between microsystems (Bronfenbrenner, 1979) and reflects how intentional or unintentional negative views are transmitted, maintained, and expanded. This level includes the interactions between the individual and family, day programs, direct support staff, mental health providers, service coordinators, doctors, et cetera. Research suggests that sexuality issues should be addressed not in isolation but through interdisciplinary team work (Lumley & Scotti, 2001). However, counselors working with other providers and family members might encounter difficulties in advocating for healthy sexuality decisions as counselors might still be opposed to attending sexual issues or changing their views regarding this topic.

Counselors need to be mindful of the interplay of different microsystems and its impact on the sexual experiences of people with disabilities, their transformative power in serving as a bridge between these subsystems, and their misconceptions about sexuality in these individuals. Consequently, counselors need to interrupt the perpetuation of negative views and include sexuality related issues into the planning of interventions in clinical treatment. Counseling programs can prepare students to identify this multisystem reality and its impact on the individual, to develop skills for creating alliances between microsystems, to instill empowerment for assuming a

collaborative role in their work with people with disabilities, as well as obtain the tools to deal with resistance and negative responses to social change (Lewis et al., 2003). One example would include encouraging counseling students to actively identify stereotypes that are perpetuated in the collaborative work with other mental health professionals and which result in barriers for people with disabilities to experience a healthier sexuality. Counselor educators might also foster discussions of these identified stereotypes to spark meaningful dialogues and critical thinking in students.

The Exosystem level consists on the interplay between social settings where the individual might not have direct influence or might not be a direct participant (Bronfenbrenner, 1979). This system level includes mass media, support systems, social security system, religious organizations, the law enforcement system, and sexual policies in the individuals' environment (i.e. day program). Even though individuals with disabilities, their families, or mental health providers might not typically participate in state divisions such as the state offices for people with developmental disabilities or national initiatives as the Americans with Disabilities Act (1990), their lives are influenced by the decisions made in these domains in terms of making resources available. Decisions about how resources are allocated for residential, vocational, educational and recreational services will impact the possibilities of mental health providers, and specifically, counselors. According to the National Association of Developmental Disabilities Councils, many of these efforts have strived for increasing self-determination, independence, inclusion and productivity in these individuals ("About Councils on Developmental Disability," n.d.). However, work still needs to be done as negative views socially held about other minorities with disabilities (LGBT) still reinforce institutional barriers that impact their possibilities for healthy sexuality at the knowledge, access and choice levels (Fraley et al., 2007).

Specifically in graduate counseling programs, concepts such as the intersection of disability and sexuality have been segregated. This has created limited training or few exposure opportunities to experiential activities aimed at raising awareness and stronger multisystemic understanding. Despite efforts to include disability aspects into counseling curricula, the number of required courses on disability issues at accredited graduate institutions is still not enough. Moreover, similar to psychology programs, "the absence of disability issues in textbooks, curricula, and in the discourse among peers and professors communicates a powerful message about marginalization of people with disabilities and trains students not to notice their absence from the field" (Olkin & Pledger, 2003, p. 57).

This might contribute to professionals graduating with deficiencies in competence and sensitivity to intervene effectively, and counselors unintentionally perpetuating marginalizing conditions for people with developmental disabilities in their access to a healthy sexuality.

The role of counseling programs includes facilitating students' identification of the impact of systems' policies in the individual's mental health and development. According to Lewis et al. (2003), counselors also need to be able to build alliances and disseminate information to debunk stereotypes regarding sexuality in people with disabilities. Counseling programs have the responsibility to equip students with the necessary tools to overcome internal barriers to truthfully look at these issues, and to encourage students to advocate for these clients in different domains (i.e., health system, agencies, graduate programs, etc.). Counselors could advocate at the agency level to foster positive and realistic views of these individuals, to make resources available for clients with disabilities, and also advocate for training opportunities in this area. Brodwin and Frederick (2010) affirm that these training suggestions are also opportunities for professionals to examine their attitudes, values, and beliefs related to these issues. Another way to intervene in the exosystem could be by encouraging faculty and supervisors to engage students in research and scholarly opportunities to foster research on sexuality issues in people with developmental disabilities (Fraley et al., 2007).

The Macrosystem level consists of the culture surrounding the individual (Bronfenbrenner, 1979) and includes societal values, belief systems, and attitudes towards sexuality and disability, gender and sexual orientation as well as the interplay with other cultural identities (race, ethnicity, age, etc.). Due to emergent views of disability that detach from the medical model, there is a growing intention to conceptualize disability as a socially constructed construct instead of an individual's pathologizing condition. However, much work is needed to bring society to a uniform view of disability as an experience instead of an excluding criteria. Moreover, the sexuality topic is greatly influenced by other cultural (e.g., spiritual and religious) views that undeniably impact counseling students and professionals at different levels.

Myths and stereotypes influence people's view of courtship, sexual relations, intimacy, and parenthood in people with developmental disabilities. For instance, reproduction and parenthood in people with disabilities have historically been defined by negative views and degrading actions as compulsory sterilization, denial of parenting opportunities, beliefs of genetic transmission of disability to offspring, prenatal testing and selective abortion, et cetera. These macrosystemic beliefs emerge in these individuals' interactions with the environment

and might reinforce oppressive cycles. The discussion of these stereotypes and oppressive cycles may create interference with other cultural values (i.e., niceness, altruism, etc.) and discomfort-laden experiences in members of mainstream culture. This might generate resistance and unwillingness to address these issues and ultimately, further marginalization for people with developmental disabilities (Stinson, 2004).

Counselors have a critical responsibility to overcome the ambivalence that generates unwillingness to address these issues and continued marginalization for people with disabilities. According to Lewis et al. (2003), counselors need to recognize the impact of oppression and also identify environmental factors that contribute to it in their clients. Counseling programs have the ethical responsibility to prepare students to become advocates in the public arena to inform, educate, and transform the oppressive policies that affect people with developmental disabilities. Furthermore, counseling programs and supervisors need to train counseling students for making alliances, influencing legislators, organizing efforts, and maintaining open dialogues with communities and clients. A potential way to do this is by encouraging critical, and often difficult, dialogues in counseling students about able-body privilege and macrosystemic negative views that perpetuate marginalization and oppression in people with disabilities.

## Conclusion

The field of developmental disabilities has been historically influenced by misconceptions, societal negative perceptions, and dehumanizing practices. These negative societal views and historical antecedents not only inform the way people perceive individuals with disabilities, but also how these individuals perceive themselves (Brodwin & Frederick, 2010; Stinson et al., 2002). This situation becomes more complex when disability identity intersects with other oppressed identities. For example, in the case of women or LGBTQ individuals, the stereotypes people hold might place them in a situation where they might be devalued because of their disability and also because they are associated with other historically oppressed groups (Fraleley et al., 2007). However, for individuals with developmental disabilities in general, these societal views and stereotypes may impact almost every aspect of life such as relationships, achievements, happiness, creativity, and intimacy (Brodwin & Frederick, 2010). Thus, the disability field poses an imperative call for mental health professionals to overcome their personal barriers in talking about sexuality in developmental disabilities, understand the multisystemic reality of oppression, and respond to

client needs by advocating and fostering social change. Counseling programs need to empower students to understand and take on their revolutionary role in the professional field as well as embrace their advocacy power.

In her study, Gougeon (2010) affirms the difficulty to translate knowledge into practice when addressing sexual knowledge in individuals with developmental disabilities. Stinson (2004) asserts the same difficulty in the mental health field as social change takes time and united efforts. She suggests that professionals work under the model of small wins where success is not measured by the solution of all the issues described in this article, but by small victories in every ecological level, each day. Counseling programs could benefit from using this approach when integrating advocacy skills into curricula and when prompting students to engage in difficult dialogues. Thus the transformational power is processed in a less overwhelming manner and becomes more manageable for counseling students and supervisors. As counselor educators, it is our ethical responsibility to make this happen and instill in our students that “there is no single reason why people with developmental disabilities continue to be at a disadvantage when it comes to sexual development and expression” (Stinson, 2004, p. 142).

## References

- American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.
- Americans With Disabilities Act of 1990, Pub. L., No. 101-336, § 2, 104 Stat. 328 (1991).
- Arokiasamy, C. M. V., Rubin, S. E., & Roessler, R. T. (2008). Sociological aspects of disability. In S. E. Rubin & R. T. Roessler (Eds.), *Foundations of vocational rehabilitation process* (pp. 167-195). Austin, TX: Pro-ed.
- Ashby, C. (2012). Disability studies and inclusive teacher preparation: A socially just path for teacher education. *Research and Practice for Persons with Severe Disabilities*, 37(2), 89-99. doi:10.2511/027494812802573611
- Ballan, M. (2012). Parental perspectives of communication about sexuality in families of children with autism spectrum disorders. *Journal of Autism & Developmental Disorders*, 42(5), 676-684. doi:10.1007/s10803-011-1293-y
- Ballan, M., Romanelli, M., & Harper, J. N. (2011). The social model: A lens for counseling transgendered individuals with disabilities. *Journal of Gay & Lesbian Mental Health*, 15, 260-280. doi:10.1080/19359705.2011.582073
- Bartoli, E., Morrow, M., Dozier, C. G., Mamolou, A., & Gillem, A. R. (2014). Creating effective

- counselors: Integrated multicultural and evidence-based curricula in counselor education programs. *The Journal of the Pennsylvania Counseling Association*, 13(1), 27-38.
- Bernert, D. J. (2011). Sexuality and disability in the lives of women with intellectual disabilities. *Sexuality and Disability*, 29, 129-141. doi:10.1007/s11195-010-9190-4
- Bernert, D. J. & Ogletree, R. J. (2013). Women with intellectual disabilities talk about their perceptions of sex. *Journal of Intellectual Disability Research*, 57(3), 240-249. doi:10.1111/j.1365-2788.2011.01529.x
- Brodwin, M. G. & Frederick, P. C. (2010). Sexuality and societal beliefs regarding persons living with disabilities. *Journal of Rehabilitation*, 76(4), 37-41.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.
- Chang, C. Y., Crethar, H. C., & Ratts, M. J. (2010). Social justice: A national imperative for counselor education and supervision. *Counselor Education & Supervision*, 50, 82-87. doi:10.1002/j.1556-6978.2010.tb00110.x
- Chang, C. Y., Hays, D. G., & Milliken, T. (2009). Addressing social justice issues in supervision: A call for client and professional advocacy. *The Clinical Supervisor*, 28, 20-35. doi:10.1080/07325220902855144
- Fraley, S., Mona, L., & Theodore, P. (2007). The sexual lives of lesbian, gay, and bisexual people with disabilities: Psychological perspectives. *Sexuality Research & Social Policy*, 4(1), 15-26. doi:10.1525/srsp.2007.4.1.15
- Garland-Thomsom, R. (2012). The case for conserving disability. *Bioethical Inquiry*, 9, 339-355. doi:10.1007/s11673-012-9380-0
- Glossoff, H. L. & Durham, J. C. (2010). Using supervision to prepare social justice counseling advocates. *Counselor Education & Supervision*, 50, 116-129. doi:10.1002/j.1556-6978.2010.tb0113.x
- Goble, C. (1999). "Like the secret service isn't it". People with learning difficulties perceptions of staff and services: Mystification and disempowerment. *Disability and Society*, 14(4), 449-459. doi:10.1080/09687599926064
- Gougeon, N. (2010). Sexuality and autism: A critical review of selected literature using a social-relational model of disability. *American Journal of Sexuality Education*, 5, 328-361. doi:10.1080/15546128.2010.527237
- Hays, D. G. & Chang, C. Y. (2003). White privilege, oppression, and racial identity development: Implications for supervision. *Counselor Education & Supervision*, 43, 134-145. doi:10.1002/j.1556-6978.2003.tb01837.x
- Juergens, M. H., Miller, S., & Berven, N. (2009). Willingness of graduate students in rehabilitation counseling to discuss sexuality with clients. *Rehabilitation Counseling Bulletin*, 53(1), 34-43. doi:10.1177/0034355209340587
- Kafer, A. (2013). *Feminist queer crip*. Bloomington, IN: Indiana University Press.
- Kazukauskas, K. & Lam, C. (2010). Disability and sexuality: Knowledge, attitudes, and level of comfort among certified rehabilitation counselors. *Rehabilitation Counseling Bulletin*, 54(1), 15-25. doi:10.1177/0034355209348239
- Lewis, J., Arnold, M. S., House, R., & Toporek, R.L. (2003). *ACA Advocacy Competencies*. Retrieved from [http://www.counseling.org/docs/competencies/advocacy\\_competencies.pdf](http://www.counseling.org/docs/competencies/advocacy_competencies.pdf)
- Linton, S. (1998). *Claiming disability*. New York, NY: New York University Press.
- Lumley, V. A. & Scotti, J. R. (2001). Supporting the sexuality of adults with mental retardation: Current status and future directions. *Journal of Positive Behavior Interventions*, 3(2), 109-119. doi:10.1177/109830070100300208
- Meaney-Tavares, R. & Gavidia-Payne, S. (2012). Staff characteristics and attitudes towards the sexuality of people with intellectual disability. *Journal of Intellectual & Developmental Disability*, 37(3), 279-273. doi:10.3109/13668250.2012.701005
- National Association of Developmental Disabilities Councils. (n.d.). About councils on developmental disability. Retrieved from <http://www.nacdd.org/Home.php>
- O'Brien, G. V. (2011). Eugenics, genetics, and the minority group model of disability: Implications for social work advocacy. *Social Work*, 56(4), 347-354. doi:10.1093/sw/56.4.347
- Olkin, R. & Pledger, C. (2003). Can disability studies and psychology join hands? *American Psychologist*, 58(4), 296-304. doi:10.1037/0003-066x.58.4.296
- Pledger, C. (2003). Discourse on disability and rehabilitation issues: Opportunities for psychology. *American Psychologist*, 58(4), 279-288. doi:10.1037/0003-066x.58.4.279
- Rivera, P. (2008). Sexualidad de los niños, niñas y jóvenes con discapacidad. *Revista Educación*, 32(1), 157-170. doi:10.15517/revedu.v32i1.529
- Robinson, C. P., Conahan, F., & Brady, W. (1992). Reducing self-injurious masturbation using a least intrusive model and adaptive equipment. *Sexuality and Disability*, 10, 43-55. doi:10.1007/bf01102247
- Schulz, S. (2009). Psychological theories of disability and sexuality: A literature review. *Journal of*

- Human Behavior in the Social Environment*, 19, 58-69. doi:10.1080/10911350802631578
- Smart, J. F. & Smart, D. W. (2006). Models of disability: Implications for the counseling profession. *Journal of Counseling & Development*, 84, 29-40. doi:10.1002/j.1556-6678.2006.tb00377.x
- Smith, L., Foley, P., & Chaney, M. (2008). Addressing classism, ableism, and heterosexism in counselor education. *Journal of Counseling & Development*, 86, 303-309. doi:10.1002/j.1556-6678.2008.tb00513.x
- Stinson, J. (2004). *A systems approach to the development of a model of sexuality for adults with developmental disabilities* (Doctoral dissertation, Alliant International University). Retrieved from <http://search.proquest.com.libezproxy2.syr.edu/pqdftt/docview/305053816/fulltextPDF/D030CECD1CAC4A1APQ/1?accountid=14214>
- Stinson, J., Christian, L. A., & Dotson, L. A. (2002). Overcoming barriers to the sexual expression of women with developmental disabilities. *Research & Practice for Persons with Severe Disabilities*, 27(1), 18-26. doi:10.2511/rpsd.27.1.18
- Strickler, H. L. (2001). Interaction between family violence and mental retardation. *Mental Retardation*, 39(6), 461-471. doi:10.1352/0047-6765(2001)039<0461:ibfvam>2.0.co;2
- Watt, S., Curtis, G., Drummond, J., Kellogg, A., Lozano, A., Tagliapietra, G., & Rosas, M. (2009). Privileged identity exploration: Examining counselor trainee's reactions to difficult dialogues. *Counselor Education & Supervision*, 49, 86-105. doi:10.1002/j.1556-6978.2009.tb00090.x
- Wolfe, P. S. & Blanchett, W. J. (2000). Moving beyond denial, suppression and fear to embracing the sexuality of people with disabilities. *TASH Newsletter*, 26(5), 5-7.

# The Development and Evaluation of a Mental Health Training for Foster Parents

Michael T. Morrow, Brooke E. Garwood, Lisa M. Brutko, Christina A. Schneider, and Jessica A. Cuttic

The authors outline the development, delivery, and evaluation of a mental health workshop series for foster parents. A needs assessment was conducted, and workshops were created by reviewing research on developmental psychopathology and empirically supported psychotherapies. Participants (N = 35 foster parents) reported a moderate level of satisfaction with the workshops and offered valuable open-ended feedback. This paper is intended as a resource for mental health providers conducting similar work with foster families.

*Keywords:* Foster care, mental health, program development and evaluation

In 2012, nearly 400,000 U.S. youth were estimated to be living in foster care, with over 250,000 entering the child welfare system that year (U.S. Department of Health and Human Services, 2013b). Foster care is defined as “24-hour substitute care for children placed away from their parents or guardians” and is provided in multiple settings (General, 2015). Data from the 2012 Adoption and Foster Care Analysis and Reporting System (AFCARS) indicate that 47% of foster youth resided in homes with nonrelative foster parents, 28% resided in homes with relative foster parents, and the remainder were placed across institutions, group homes, preadoptive placements, trial home visits, and supervised independent living programs (U.S. Department of Health and Human Services, 2013a).

Children may enter foster care as early as infancy and remain in the system up to 18 to 21 years, depending on state policies (Fostering Connections to Success and Increasing Adoptions Act, 2008). According to the 2012 AFCARS data, the median age of youth in foster care was 8.5 years, with a median age of entry of 6.5 years and a median age of exit of 8.2 years. Boys have consistently outnumbered girls in foster care over the past decade by 4% to 6%. Youth of color are also disproportionately represented. In 2012, 42% of foster youth were White, 26% were Black, 21% were Hispanic, 6% were of two or more races, 2% were years, the number of youth in foster care has decreased American Indian/Alaskan Native, and less than 1% were Asian or Native Hawaiian/Pacific Islander (Child

Welfare Information Gateway, 2013). In the last 10 across all races/ethnicities (except for multiracial youth), with the most dramatic reduction for Black youth, a 47% drop (Administration of Children, Youth and Families, 2013).

The U.S. foster care system has evolved in many ways, and current priorities include: placing youth with extended family, reducing the overall length of placement, accelerating legal proceedings, reunifying youth with their preplacement families, and working toward adoption when reunification is not feasible (Simms, Dubowitz, & Szilagyi, 2000). Over time, emphasis on reunification has been tempered with securing permanent placements with caring parents, which may be with relative or nonrelative caregivers (Child Welfare Information Gateway, 2013; Levesque, 2014). Of the over 240,000 youth discharged in 2012, 51% were reunited with their families, 21% were adopted, and 10% were emancipated; the remaining youth were placed with legal guardians or experienced other outcomes. Nearly half stayed in foster care for a year or less, while a small subset, approximately 6%, remained in care for 5 or more years (Child Welfare Information Gateway, 2013). In the past decade, the average length of stay has dropped by nearly nine months (Administration of Children, Youth and Families, 2013).

## Foster Youth and Mental Health

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Although foster youth are a highly heterogeneous group of children and adolescents, they display a disproportionately high rate of health problems, including chronic medical conditions, developmental delays, intellectual and learning disabilities, and mental illnesses (Chernoff, Coombs-Orme, Risley-Curtiss, & Heisler, 1994; Kavalier & Swire, 1983). Compared to children from similar demographic backgrounds, foster youth are substantially more likely to display behavior problems, be diagnosed with psychiatric disorders, and take psychotropic medication (Hulsey & White, 1989; McIntyre & Keesler, 1986; Takayama, Bergman, & Connell, 1994). Numerous psychiatric conditions are elevated in foster youth relative to peers not placed in foster care, including anxiety disorders, mood disorders, conduct disorders, and attention-deficit/hyperactivity disorder (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Halfon, Mendonca, & Berkowitz, 1995). Furthermore, youth with psychiatric diagnoses tend to remain in foster care for longer periods and are more likely to experience multiple placements (Fanshel & Shin, 1978; Simms & Halfon, 1994).

There are many pathways into foster care, such as poverty, homelessness, parental psychopathology or substance use, community violence, and child abuse or neglect (Arad, 2001; Cicchetti & Toth, 2000; Simms et al., 2000). Each of these factors has been associated with social, emotional, or behavioral difficulties in childhood (Evans & English, 2002; Fowler, Tompsett, Braciszewski, Jacques-Tiura, & Baltes, 2009; Goodman & Gotlib, 1999; Hawkins, Catalano, & Miller, 1992; Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann, 1993). Moreover, many of them tend to co-occur and enhance youth's vulnerability to psychosocial disturbance in a cumulative fashion (Rutter, 1981; Sameroff, 1998).

In particular, child maltreatment and inadequate caregiving have been linked to maladaptive patterns in critical aspects of development, including attachment status and attachment-related behavior (Cyr, Euser, Bakermans-Kranenburg, & vanIJendoorn, 2010; Stovall & Dozier, 2000) as well as physiological and behavioral regulation (Bernard, Butzin-Dozier, Rittenhouse, & Dozier, 2010; Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007). Insecure or disorganized attachments, along with compromised self-regulation, could each give rise to a variety of psychiatric disorders and functional impairments over time. Accordingly, the very factors that drive youth into child welfare also appear to enhance their risk for mental health challenges, which in turn perpetuate the

length of their stay and disruptions in care.

Foster youth also appear more prone to poor functional outcomes in adulthood, such as unemployment, homelessness, physical illness, substance use, suicide attempts, and interpersonal difficulties (Benedict, Zuravin, & Stallings, 1996; Cook-Fong, 2000; Dumaret, Coppel-Batsch, & Couraud, 1997; Susser, Lin, Conover, & Struening, 1991). Yancey (1992) suggests that racial/ethnic minority youth are at especially high risk for such outcomes after departing the system. In light of these findings, many have argued that foster care has failed to adequately prepare youth for their transitions to life as independent adults (Barth, 1990; Cook, 1991).

Fortunately, legislators have recognized this failure and increased funding toward supporting foster youth with their entry into independent living by offering assistance with housing, education, employment, daily living, and health care (U.S. Department of Health and Human Services, 1999). While this legislation has increased access to services for emancipated youth, it has been criticized for unrealistically emphasizing independent living at a developmental period (18 to 21 years) when many youth still require substantial support, guidance, and education as they transition toward adulthood (Freundlich, 2010).

In sum, foster youth are a vulnerable population and especially susceptible to psychosocial difficulties before, during, and after placement. Thus, foster caregivers face a daunting task in providing these youth with the support needed to help them adjust to a new family system and prepare them for successful transitions to adulthood. With that said, specialized mental health education has been recommended for all foster parents (Lawrence, Carlson, & Egeland 2006), particularly on the topics of child development and parenting (Simms et al., 2000). Specialized knowledge and skills in these areas could play a pivotal role in derailing foster youth from paths toward serious psychopathology and promoting the development of the life skills needed to function successfully as adults.

## Current Community Service Project

In the spring of 2013, the president of a foster parent organization approached Arcadia University's Graduate Program in Counseling to discuss the possibility of offering mental health training to its parent members. Through ongoing conversation with the president, we learned that the program had not been able to consistently provide its parents with relevant

training in mental health. One faculty member (first author) agreed to supervise a small group of counseling students (second, third, and fourth authors) in developing, delivering, and evaluating a mental health workshop series for this organization in the following academic year.

To start this project, the authors worked with the president to design an initial needs assessment to evaluate the foster parents' interests in specific mental health topics. The needs assessment included a checklist in which parents were asked to identify 5 of 7 topics that most interested them. They were also encouraged to offer open-ended suggestions. The three topics endorsed most by parents were: (a) common emotional and behavioral difficulties in foster children, (b) ways to help children form more secure relationships and attachments, and (c) strategies to manage challenging behaviors in children and adolescents. Next, several months were spent developing three separate workshops focused on each topic.

Each student took the lead in developing one workshop. The faculty supervisor regularly met with the students to discuss workshop content, format, and learning activities. To develop the content, relevant theory and research in developmental psychopathology were used along with empirically supported treatment manuals. For the second workshop, several attachment-based interventions (Dozier, Zeanah, & Bernard, 2013; McNeil & Hembree-Kigin, 2010) were utilized; for the third, multiple behavioral parent training protocols (Forgatch & Patterson, 2010; Kazdin, 2005) were relied upon. Some challenges were encountered with the first workshop, insofar as making it more practical and less informational. Therefore, this workshop was piloted in a graduate counseling course to get feedback from students, and it was modified accordingly.

## Method

### Participants

At the time of this project, there were 121 families in the participating foster care organization, which is located in one suburban county of the northeastern U.S. Twenty-six parents attended the first workshop; 4 parents attended the second, and 5 parents attended the third. There was inclement winter weather on the nights of the second and third workshops, which likely restricted attendance. Data were not collected to determine whether parents attended multiple

workshops. No identifying or demographic data were gathered; however, some information about the foster parent organization is publically available.

In this county, a majority of the youth who require foster placements are relatively young (preschool and elementary school-age) and many are from racial/ethnic minority backgrounds. They require placement for multiple reasons, such as abuse, neglect, and homelessness. The county emphasizes continuity by working to keep foster youth in their communities and place siblings in the same foster home. The county also appears to strongly advocate for reunification and recently launched a program to increase the level of coordination that occurs surrounding this process. Specifically, birth parents, foster parents, caseworkers, and youth (when appropriate) collaborate to design a reunification plan that is presented to a family court judge.

According to county guidelines, all of the attendees met the following requirements to become foster parents: be at least 21 years of age, rent/own a home/apartment that meets state standards, provide a positive physical and emotional environment, and complete an orientation class and pre-service training. The initial orientation and pre-service classes require 12 hours of training. Additionally, all foster parents are required to complete a minimum of 10 hours of training each year. A foster care coordinator approved each of the mental health workshops to satisfy two training hours for all attending foster parents.

### Workshops

Each workshop lasted 120 minutes and included several didactic lessons, group discussions, and learning activities. The lessons were aimed to introduce and explain major concepts and skills; lessons were kept relatively brief and included questions to stimulate group discussion, particularly the sharing of ideas and suggestions from foster parent to foster parent. Slide presentations and corresponding handouts were also used to facilitate learning. At the start of each workshop, a clear statement was offered that the goal was not only to provide information but also to guide the foster parents in sharing their experiences and expertise. At the end of each workshop, participants completed brief program evaluation measures.

1. **Common emotional and behavioral difficulties.** The first workshop provided attendees with a broad overview of the mental health challenges faced by many foster youth. To start, the presenters stated that

foster youth are a diverse group of children and adolescents with their own unique strengths and challenges. They then shared that despite this heterogeneity, foster youth are at increased risk for social, emotional, and behavioral difficulties (Hulsey & White, 1989; McIntyre & Keesler, 1986; Takayama, Bergman, & Connell, 1994); afterward, attendees were invited to describe the mental health challenges they have observed in their foster children. Next, it was explained that foster youth often experience a history of adversity (e.g., poverty, parental psychopathology, maltreatment, and disruptions in care) that increases their vulnerability to psychosocial difficulties (Evans & English, 2002; Fowler et al., 2009; Goodman & Gotlib, 1999; Hawkins et al., 1992; Masten et al., 1993). The presenters then discussed the therapeutic potential of foster care. In particular, they emphasized the important role that foster parents play in identifying signs of emerging or worsening mental health conditions.

The presenters proceeded to discuss the commonly diagnosed psychiatric disorders in foster youth (e.g., Clausen et al., 1998; Halfon et al., 1995). To reduce the likelihood that attendees would “self-diagnose” their foster youth, the presenters avoided using the names of specific disorders and referred to five broad diagnostic clusters: attention problems and hyperactive behavior, defiant behavior and conduct problems, anxiety and fears, trauma-related behaviors, and mood difficulties. For each category, they offered a summary of the major features of the relevant disorders and encouraged the foster parents to share their personal experiences with behaviors in any of the five categories. The attendees were willing to share and discussed specific challenges they have faced and even began offering each other advice.

To refocus parents’ attention on the positive qualities of their foster children, the presenters introduced the “positive opposite” (i.e., the desired opposite of an undesired behavior; e.g., keeping hands to self versus hitting siblings; McNeil & Hembree-Kigin, 2010). They then asked attendees to complete a worksheet by identifying positive behaviors displayed by their foster children in each of the five categories and then share their answers with the larger group. Attendees were encouraged to take this worksheet home and be mindful of the “positive opposites” they observe in all their children. To close, the foster parents were advised to seek professional help if their foster children were exhibiting significantly problematic behavior or marked changes in functioning; they were also provided with a list of local mental health resources and a guide to evidence-based psychotherapies for children and adolescents.

**2. Forming secure attachments and relationships.** This workshop began with a general discussion of attachment. Attachment was defined as an affective bond that first emerges between infants and their primary caregivers (Bowlby, 1988) and promotes the development of emotion regulation (Sroufe, 1995). Before elaborating any further, the presenters explored attendees’ understanding of attachment; a strong discussion ensued, and it was clear that many had thoroughly educated themselves on this topic. A brief overview of attachment formation was then provided, which led to a discussion of the importance of attachment security, defined simply as the level of trust internalized in a bond between a caregiver and child.

Next, the presenters introduced the concept of the internal working model, defined as the schema that individuals develop for themselves, others, and their relationships (Bretherton, 1985). The internal working model was framed as a computer program that children internalize via their early attachment experiences. It was explained that individuals are thought to carry this program into social interactions, which guides them to perceive and respond to others according to their specific models. This construct is frequently cited as the mechanism that explains the connection between the quality of infants’ attachments with their caregivers and the nature of their subsequent relationships (Bernier & Dozier, 2002). The foster parents were then challenged to think about the internal working models that each of their foster children carry with them.

The rest of the workshop centered on attachment in foster youth. The presenters explained that many foster youth have a history of insecure attachment due to factors that lead to placement in child welfare; attendees were asked to explain why this may be the case with their own foster children. They highlighted many of the factors noted by research, for example, inconsistent parenting, disruptions in care, and maltreatment (Cyr et al., 2010; Stovall & Dozier, 2000). Next, a brief review was presented of the correlates and consequences thought to be linked to insecure attachment, including deficits in physiological and behavioral regulation (Bernard et al., 2010; Lewis et al., 2007) and problematic interpersonal relations (Bernier & Dozier, 2002). Of note, conversation was intentionally shifted away from the topic of Reactive Attachment Disorder, given its widespread misunderstanding and misuse (Allen, 2011).

Finally, time was spent considering ways to build strong and secure bonds with foster youth. It was explained that the foster parents are likely doing their best to provide their foster children with a corrective

emotional experience (Teyber, 2000) by offering the secure base of an available and responsive caregiver. Three key elements of attachment-focused care were highlighted: consistency, nurturance, and synchrony. Consistency was defined as providing stable and predictable caregiving; nurturance was described as offering protection and support when youth are distressed; synchrony was portrayed as parents' capacity to read their children's cues to meet their changing needs (Dozier et al., 2013). Although these concepts are typically discussed for infants, the presenters explored how they could be applied for older youth. While several methods were recommended (e.g., child-directed interaction for young children and active listening for teens), the attendees were guided to generate their own ideas as the presenters offered feedback to ensure their suggestions were in line with the three key elements.

**3. Managing challenging behavior.** The third and final workshop began with a discussion of common disruptive behaviors and conduct problems in children and adolescents. The presenters made an effort to distinguish behaviors from attributes to shift attendees' potential thinking away from "challenging child" to "challenging behavior." A brief summary was also offered of prominent risk factors for problematic behavior, including aspects of temperament, neuropsychological deficits, parenting style, and family dysfunction (Aguilar, Sroufe, Egeland, & Carlson, 2000; Moffitt, 1993; Russell, Hart, Robinson, & Olsen, 2003).

Extra emphasis was placed on positive parenting, particularly the authoritative parenting style (Baumrind, 1966), which was described as a combination of high demand (e.g., clear expectations, monitoring and supervision, and enforced consequences) and responsiveness, such as positive affect, physical affection, active listening (Maccoby & Martin, 1983). The presenters announced that while all children require a somewhat individualized parenting approach, the authoritative style provides an excellent foundation from which to build. Some common parenting behaviors that inadvertently contribute to misbehavior (e.g., general inconsistency, modeling negative behavior, accidental reinforcement, yelling, shaming, and corporal punishment; Kazdin, 2005) were also discussed.

Next, an adapted version of the basket system was introduced (Greene, 1998). This system is a visual model for classifying and responding to children's desired and undesired behavior; it is intended to equip parents with a clear and efficient repertoire of responses

to the wide spectrum of behaviors that children exhibit. There are three baskets, each filled with different categories of behavior: (a) positive behavior (e.g., following directions and completing chores), (b) minor misbehavior (e.g., whining and repeated questions), and (c) serious misbehavior (e.g., physical aggression and property destruction). The first step in applying this model is to catch a behavior and decide in which basket it belongs. Attendees were challenged to categorize several example behaviors and also asked to generate examples of their own.

Then, the presenters explained how to respond to the behaviors in each basket. For the first basket holding positive behaviors, some form of positive attention is needed, and multiple methods of positive reinforcement (e.g., attention, affection, praise, recognition, privileges, and rewards) were discussed. The foster parents were then asked to practice using labeled praise via brief role-plays. For the second basket, which holds undesired yet minor misbehavior, planned ignoring was recommended to extinguish these behaviors. It was acknowledged how challenging it can be to ignore such behaviors and parents were warned about a possible extinction burst (i.e., some behaviors might increase before they decrease). The parents also practiced planned ignoring in brief role-plays. Finally, non-aversive consequences (e.g., time-out, removal of privileges, positive practice, and overcorrection) were described to address the serious misbehaviors in the third basket. In covering each basket, the parents shared their experiences managing foster youths' difficult behaviors and noted what has worked and has not.

### Measures

After every workshop, all attendees were asked to complete a brief survey, the Client Satisfaction Questionnaire (CSQ-8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979). The CSQ-8 was developed for use in mental health programs and includes eight rating scale items (Likert-type scale of 1 to 4) intended to assess consumers' satisfaction with the services received. A total satisfaction score is calculated by summing a respondent's ratings for all items (range of 8 to 32), and higher scores indicate greater satisfaction. For clarity, seven of the eight items were adapted by replacing the term "service" with "workshop" (e.g., "To what extent has our workshop met your needs?"). The CSQ-8 evidenced high test-retest reliability (LeVois, Nguyen, & Attkisson, 1981), strong internal consistency (Cox, Brown, Peterson, & Rowe, 1982; Roberts & Attkisson, 1983), and concordance with several service-related

outcomes (Attkisson & Zwick, 1982).

Following the CSQ-8, workshop attendees were asked to complete two open-ended items. The first item (“Please list two topics that you understand better after the workshop”) was intended to identify the specific concepts and skills that participants understood better via the workshop. The second item (“Please offer any comments or suggestions to make this workshop more helpful”) was aimed to gather more precise information on attendees’ perceptions of the workshop, along with their ideas for strengthening future workshops.

## Results

Across workshops, the 35 participants reported a mean CSQ-8 total satisfaction score of 24.69 ( $SD = 3.53$ ). There was relatively limited variability in total satisfaction means between the workshops: 1 ( $n = 26$ ,  $M = 24.08$ ,  $SD = 3.48$ ), 2 ( $n = 4$ ,  $M = 25.75$ ,  $SD = 4.57$ ), and 3 ( $n = 5$ ,  $M = 27.00$ ,  $SD = 2.12$ ). Given the small number of attendees for the second and third workshops, we did not test the statistical significance of differences in satisfaction among the three workshops. Also, because no demographic data were collected, relations of individuals’ characteristics were not examined (e.g., age, sex, race/ethnicity, marital status, length of time spent fostering youth, and number of current/past foster children served) with their ratings.

The first four authors examined qualitative data to identify common themes and categories for each workshop. For both open-ended items, the authors first reviewed responses separately to generate lists of recurring themes and categories. They then met together to compare lists, resolve differences, and consolidate their findings into one final list. Across workshops, attendees reported learning most about three topics: (a) common behavior problems, (b) difficulties with attention, and (c) the importance of consistency in parenting. They also commented on several positive aspects of the workshops, including their basic organization and the workshop facilitators’ presentation skills. Moreover, they provided two consistent suggestions: (a) offer more specific examples of challenging behaviors and how to address them and (b) provide greater opportunity for interactive learning via discussion and activities.

## Discussion

Over the course of one year, three counseling students worked with a counselor educator to develop

three separate workshops and deliver them to 35 foster parents. Overall, the attendees were moderately satisfied with the workshops and reported increased knowledge in several areas. They also appeared to appreciate several specific aspects of the workshops and offered constructive suggestions to strengthen future workshops.

### Strengths of Workshops

The current project has several strengths. First, the authors made an effort to collaborate with the foster parent organization to design workshops to match their specific needs and interests. This was accomplished through ongoing conversation with the organization’s president and an initial needs assessment of its members. As a result, the authors identified three topics for the workshops and learned of group members’ preferred training formats and methods.

By gathering these data ahead of time, the authors were able to individualize the workshops to the foster parents’ specific interests and preferences. This approach is similar to participatory action research (PAR), a framework for engaging and empowering communities in developing and evaluating programs (Hughes, 2003). Following this model, professionals work with communities to collaboratively design, assess, and adapt programs. A PAR framework is strongly recommended for professionals who develop mental health programs for foster parents. Given the unique mental health challenges faced by foster families along with variation between foster care agencies (e.g., in policies, practices, and populations), it is critical to integrate the unique interests, concerns, and needs of foster care communities into programs for its members.

A second strength of this project is the team’s commitment to following an evidence-based model in developing the content of all workshops. As noted earlier, relevant theories and research were reviewed and evaluated in selecting the specific concepts and skills to share with foster parents. Throughout this process, the authors made an effort to identify pertinent empirically supported interventions; two resources were especially useful: (a) Weisz and Kazdin’s (2010) volume of evidence-based interventions for children and adolescents and (b) the Journal of Clinical Child and Adolescent Psychology’s ten-year update on empirically supported treatments for youth (Silverman & Hinshaw, 2008).

Notably, some initial difficulty was encountered in identifying attachment-focused interventions with a

solid base of evidence. In fact, several attachment-oriented interventions (e.g., rebirthing and holding therapy) are largely unscientific and have been found to be harmful, even lethal in some cases (Allen, 2011; Lilienfeld, 2007). Unfortunately, these interventions may have tarnished the name for other attachment-based therapies that are firmly grounded in scientific theory and research, such as Mary Dozier's Attachment and Biobehavioral Catch-up and Charles Zeanah's New Orleans Intervention (Dozier et al., 2013).

Third, participants reported that the workshops were organized and presented well. This is likely attributable to several factors. During the development process, just as much time was spent discussing what to present as was discussing how to present it. The faculty supervisor met with students individually and as a group to introduce a variety pedagogical strategies and group facilitation methods. As noted previously, the first workshop was piloted in a counseling course to gain feedback from students. By emphasizing process as much as content in designing the workshops, the presenters were able to engage the foster parents and promote greater learning. The students also reported feeling more confident in delivering the workshops.

### Areas for Improvement in the Workshops

Participants provided valuable open-ended feedback regarding ways to strengthen the workshops. In particular, they requested additional concrete examples (e.g., specific child behaviors and caregiver responses) during the lecture portions of the workshops. During several workshops, attendees asked for examples, and the student facilitators had some difficulty generating them; however, they did successfully elicit examples from the other foster parents. As students, the presenters obviously lacked some field experience; thus, it is important for them to think of possible examples ahead of time and for their supervisors to share clinical examples with them, which they can then share with the larger group as needed.

Attendees also indicated that they desired more group discussion during the workshops. While discussion questions were planted throughout, it appears that the presenters could have worked to facilitate greater discussion among attendees. Furthermore, the participants requested more time to practice skills. Although the third workshop included two skills-based role-play activities, the other workshops were quite limited in their emphasis on skill building. In future workshops, additional examples will be offered along with more opportunity for both group

discussion and skills-based practice activities; however, to accomplish this, it may be necessary to extend the length of the workshops (e.g., from 2 to 3 hours).

### Limitations of Evaluation

The authors were asked to design a workshop series to fit within the parameters of an existing foster parent training program. In doing so, they were asked to maximize the amount of instruction time by keeping assessment brief; thus, a short 8-item measure was used (CSQ-8; Larson et al., 1979) with just two additional open-ended items. Accordingly, relatively scant data were collected from which to evaluate the workshops. With additional time, a slightly longer and more complex measure of consumer satisfaction would have been helpful, especially one that includes multiple dimensions of satisfaction such as the Reid-Gundlach Social Service Satisfaction Scale (Reid & Gundlach, 1983). Also, it would have been useful to offer a stronger assessment of attendees' learning (i.e., gains in knowledge). For the current assessment, just one open-ended item was used to assess participants' perceived learning, not their actual learning.

In addition to limited data, relatively few foster parents attended the workshops, particularly the second and third workshops. With the hazardous weather, the presenters considered rescheduling the final two workshops; however, this was not feasible for the foster care organization. Therefore, it is difficult to gauge whether the data collected is representative of the larger organization. Furthermore, due to small subsample sizes, it was not possible to test whether participants were significantly more satisfied with certain workshops over others. In future work with this organization, it will be important to attract more attendees to not only reach a greater number of foster parents but also evaluate the workshops more effectively.

### Benefits for Counseling Students

The current project appeared to provide numerous benefits to the graduate students involved. First, the students gained practical experience developing a mental health educational program. In designing each workshop, they also learned specific knowledge about foster youth, foster families, and the larger child welfare system. Throughout this process, they practiced using an evidence-based model of program development by reviewing and evaluating relevant theory and research on their workshop topics.

Additionally, the students were able to further develop their teaching and group facilitation skills. At least two of the students hope to make teaching a part of their eventual careers as professional counselors. Accordingly, such projects can provide students who hope to teach with practical experience in this area.

In delivering the workshops, students were also able to practice honing a number of important counseling skills (e.g., reflecting, normalizing, and validating) and also practice discussing and demonstrating specific techniques from empirically supported therapies (i.e., behavioral parent training and attachment-based interventions). By collecting, reviewing, and interpreting the evaluation data, students also practiced applying data to assess a program and refine it for future implementation. Lastly, it should be noted that one student joined this project to work on her own anxiety about public speaking, which she managed well. Accordingly, program development and evaluation projects provide counseling students with opportunities for academic, clinical, and personal growth; and hopefully, they inspire graduates to continue this type of community-based work throughout their careers.

Despite these apparent benefits, it is important to systematically evaluate student outcomes from service-based training experiences. Multiple methods (e.g., interviews, surveys, and written reflections) have been used to gather quantitative and qualitative data to assess the benefits of service learning (Koch, Ross, Wendell, & Aleksandrova-Howell, 2014; Smith, Jennings, & Lakhan, 2014). Smith and colleagues (2014) developed a brief open-ended survey to evaluate a study abroad service learning program with five items gauging the impact on students' personal development and professional growth as counselors (i.e., their theoretical perspectives, approach to providing services, and cultural competency). The final survey item asks students for feedback to strengthen the program itself. This survey could be easily adapted to assess the current project with foster families and for other similar training experiences. It will also be helpful to have students set personal goals prior to the project (e.g., developing stronger group facilitation skills) and repeatedly assess their progress toward reaching their objectives.

## References

Administration of Children, Youth and Families, Office of Data, Analysis, Research, & Evaluation. (2013).

- Recent demographic trends in foster care.* Retrieved from <http://www.acf.hhs.gov/programs/cb/resource/data-brief-trends-in-foster-care-1>
- Aguilar, B., Sroufe, L.A., Egeland, B., & Carlson, E. (2000). Distinguishing the early-onset/persistent and adolescence-onset antisocial behavior types: From birth to 16 years. *Development and Psychopathology, 12*, 109-132. doi: 10.1017/s0954579400002017
- Allen, B. (2011). The use and abuse of attachment theory in clinical practice with maltreated children, part II: Treatment. *Trauma, Violence, & Abuse, 12*, 13-22. doi: 10.1177/1524838010386974
- Arad, B.D. (2001). Parental features and quality of life in the decision to remove children at risk from home. *Child Abuse & Neglect, 25*, 47-64. doi: 10.1016/S0145-2134(00)00229-5
- Attkisson, C.C. & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning, 6*, 299-314. doi:10.1016/0149-7189(82)90074-X
- Barth, R.P. (1990). On their own: The experiences of youth after foster care. *Child and Adolescent Social Work Journal, 7*, 419-440. doi: 10.1007/BF00756380
- Baumrind D. (1966). Effects of authoritative parental control on child behavior. *Child Development, 37*, 887-907. doi: 10.1111/j.1467-8624.1966.tb05416.x
- Benedict, M.I., Zuravin, S., & Stalling, R.Y. (1996). Adult functioning of children who lived in kin versus nonrelative family foster homes. *Child Welfare, 75*, 529-549. doi: 10.1093/acprof:oso/9780195109405.003.0013
- Bernard, K., Butzin-Dozier, Z., Rittenhouse, J., & Dozier, M. (2010). Cortisol production patterns in young children living with birth parents vs children placed in foster care following involvement of Child Protective Services. *Archives of Pediatrics and Adolescent Medicine, 164*, 438-443. doi:10.1001/archpediatrics.2010.54
- Bernier, A., & Dozier, M. (2002). The client-counselor match and the corrective emotional experience: Evidence from interpersonal and attachment research. *Psychotherapy: Theory, Research, Practice, Training, 39*, 32-43. doi: 10.1037/0033-3204.39.1.32
- Bowlby, J. (1988) *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

- Bretherton, I. (1985). Attachment theory: Retrospect and prospect. *Monographs of the Society for Research in Child Development*, 50, 3-35. doi: 10.2307/3333824
- Chernoff, R., Combs-Orme, T., Risley-Curtiss, C., & Heisler, A. (1994). Assessing the health status of children entering foster care. *Pediatrics*, 93, 594-601. doi: 10.1177/104973159600600403
- Cicchetti, D., & Toth, S. L. (2000). Developmental processes in maltreated children. In D. J. Hansen (Ed.), *46th Annual Nebraska Symposium on Motivation: Motivation and child maltreatment* (pp. 85-160). Lincoln, NE: University of Nebraska Press.
- Clausen, J. M., Landsverk, J., Granger, W., Chadwick, D., & Litrownik, A. (1998). Mental health problems of children in foster care. *Journal of Child & Family Studies*, 7, 283-296. doi: 10.1023/a:1022989411119
- Cook, R. (1991). *A national evaluation of Title IV-E foster care independent living programs for youth: Phase 2, final report*. Rockville, MD: Westat, Inc. Retrieved from <http://files.eric.ed.gov/fulltext/ED348599.pdf>
- Cook-Fong, S. (2000) The adult well-being of individuals reared in family foster care placements. *Child and Youth Care Forum*, 29, 7-25. doi: 10.1023/a:1009440422651
- Cox, J.B., Brown, T.R., Peterson, P.D., & Rowe, M.M. (1982). A report on a statewide community mental health center outcome study. *Community Mental Health Journal*, 18, 135-150. doi: 10.1007/bf00754457
- Cyr, C., Euser, E.M., Bakermans-Kranenburg, M.J., & Van IJzendoorn, M.H. (2010). Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology*, 22, 87-108. doi: 10.1017/s0954579409990289
- Dozier, M., Zeanah, C.H., & Bernard, K. (2013). Infants and toddlers in foster care. *Child Development Perspectives*, 7, 166-171. doi: 10.1111/cdep.12033
- Dumaret A.C., Coppel-Batsch, M., Couraud. S. (1997). Adult outcome of children reared for long term period in foster families. *Child Abuse & Neglect*, 21, 911-927. doi: 10.1016/s01452134(97) 00053-7
- Evans, G.W., & English, K. (2002). The environment of poverty: Multiple stressor exposure, psychophysiological stress, and socioemotional adjustment. *Child Development*, 73, 1238-1248. doi: 10.1111/1467-8624.00469
- Fanshel, D., & Shinn, E. (1978). *Children in foster care: A longitudinal investigation*. New York, NY: Columbia University Press.
- Forgatch, M.S., & Patterson, G.R. (2010). Parent Management Training-Oregon Model: An intervention for antisocial behavior in children and adolescents. In J. Weisz & A. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 159-178). New York, NY: Guilford.
- Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351 § 1, 122 Stat. 3949 (2008).
- Fowler, P.J., Tompsett, C.J., Braciszewski, J.M., Jacques-Tiura, A.J., & Baltes, B.B. (2009). Community violence: A meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. *Development and Psychopathology*, 21, 227-259. doi: 10.1017/s0954579409000145
- Freundlich, M. (2010). *Chafee plus ten: A vision for the next decade: The Jim Casey Youth Opportunities Initiative*. Retrieved from <http://www.jimcaseyyouthorg/filedownload/331>
- General, 45 C.F.R., §1355 (2015). Retrieved from <http://www.ecfr.gov/cgi-bin/ECFR?page=browse>
- Goodman S.H. & Gotlib, I.H. (1999). Risk for psychopathology in the children of depressed mothers: A developmental model for understanding mechanisms of transmission. *Psychological Review*, 106, 458-490. doi: 10.1037/0033-295x.106.3.458
- Greene, R.W. (1998). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children*. New York, NY: Harper Collins.
- Halfon, N., Mendonca, A., & Berkowitz, G. (1995). Health status of children in foster care: The experience of the center for the vulnerable child. *Archives of Pediatric and Adolescent Medicine*, 149, 383-39. doi: 10.1001/archpedi.1995.02170160040006
- Hawkins, J.D., Catalano, R.F. and Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, 112, 64-105. doi: 10.1037/0033-2909.112.1.64
- Hughes, J.N. (2003). Commentary: Participatory action research leads to sustainable school and community improvement. *School Psychology Review*, 32, 38-43. doi: 10.1016/s0022-4405

- (00)00041-8
- Hulsey, T.C., & White, R. (1989). Family characteristics and measures of behavior in foster and nonfoster children. *American Journal of Orthopsychiatry*, *59*, 502-509. doi: 10.1111/j.1939-0025.1989.tb02739.x
- Kavaler, F., and Swire, M.R. (1983). *Foster Child health care*. Lexington, MA: Lexington Books.
- Kazdin, A.E. (2005). *Parent management training: Treatment of oppositional, aggressive, and antisocial behavior in children and adolescents*. New York, NY: Oxford University Press.
- Koch, J.M., Ross, J.B., Wendell, J., & Aleksandrova-Howell, M. (2014). Results of cultural immersion service learning activism with peers: Anticipated and surprising. *The Counseling Psychologist*, *42*, 1215-1246. doi: 10.1177/0011000014535955
- Larsen, D.L., Attkisson, C.C., Hargreaves, W.A., & Nguyen, T.D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, *2*, 197-207. doi: 10.1016/0149-7189(79)90094-6
- Lawrence, C., Carlson, E., & Egeland, B. (2006). The impact of foster care on development. *Development and Psychopathology*, *18*, 57-76. doi: 10.1017/s0954579406060044
- Levesque, R.J.R. (2014). Adoption and Safe Families Act. In R. J. R. Levesque (Ed.) *Encyclopedia of Adolescence* (pp. 74-76). New York, NY: Springer.
- LeVois, M., Nguyen, T.D., & Attkisson, C.C. (1981). Artifact in client satisfaction assessment: Experience in community mental health settings. *Evaluation and Program Planning*, *4*, 139-150. doi: 10.1016/0149-7189(81)90004-5
- Lewis, E., Dozier, M., Ackerman, J., & Sepulveda-Kozakowski, S. (2007). The effect of caregiving instability on adopted children's inhibitory control abilities and oppositional behavior. *Developmental Psychology*, *43*, 1415-1427. doi: 10.1037/0012-1649.43.6.1415
- Lilienfeld, S.O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, *2*, 53-70. doi: 10.1111/j.1745-6916.2007.00029.x
- Maccoby E.E., & Martin, J.A. (1983). Socialization in the context of the family: Parent-child interaction. In P.H. Mussen (Ed.) and E.M. Hetherington (Vol. Ed.), *Handbook of child psychology: Socialization, personality, and social development* (4th ed., Vol. 4, pp. 1-101). New York, NY: Wiley.
- Masten, A.S., Miliotis, D., Graham-Bermann, S.A., Ramirez, M.L., & Neemann, J. (1993). Children in homeless families: Risks to mental health and development. *Journal of Consulting and Clinical Psychology*, *61*, 335-343. doi: 10.1037 //0022-006x.61.2.335
- Mathison, S. (2008). What is the difference between evaluation and research-and why do we care? In N. Smith & P. Brandon (Eds.), *Fundamental issues in evaluation* (pp. 183- 196). New York, NY: Guilford.
- McIntyre, A., & Keesler, T.Y. (1986). Psychological disorders among foster children. *Journal of Clinical Child Psychology*, *15*, 297-303. doi: 10.1207/s15374424jccp1504\_2
- McNeil, C.B., & Hembree-Kigin, T. (2010). *Parent-Child Interaction Therapy: Second Edition*. New York, NY: Springer.
- Moffitt, T.E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. *Psychological Review*, *100*, 674-701. doi: 10.1037/0033-295x.100.4.674
- Protection of Human Subjects, 45 C.F.R. § 46 (2015). Retrieved from <http://www.ecfr.gov/cgi-bin/ECFR?page=browse>
- Reid, P.N., & Gundlach, J.H. (1983). A scale for the measurement of client satisfaction in the social services. *Journal of Social Service Research*, *7*, 37-54. doi: 10.1300/j079v07n01\_03
- Roberts, R.E., & Attkisson, C.C. (1983). Assessing client satisfaction among Hispanics. *Evaluation and Program Planning*, *6*, 401-413. doi: 10.1016/0149-7189(83)90019-8
- Russell, A., Hart, C., Robinson, C., & Olsen, S (2003). Children's sociable and aggressive behaviour with peers: A comparison of the US and Australia, and contributions of temperament and parenting styles. *International Journal of Behavioral Development*, *27*, 74-86. doi: 10.1080/01650250244000038
- Rutter, M. (1981). Stress, coping, and development: Some issues and some questions. *Journal of Child Psychology and Psychiatry*, *22*, 323-356. doi: 10.1111/j.1469-7610.1981.tb00560.x
- Sameroff, A.J. (1998). Environmental risk factors in infancy. *Pediatrics*, *102*, 1287-1292. doi: 10.1542 /peds.2007-0846o
- Silverman, W.K., & Hinshaw, S.P. (2008). The second special issue on evidence-based psychosocial treatments for children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, *37*, 1-7. doi: 10.1080/15374410701817725
- Simms, M.D., Dubowitz, H., & Szilagyi, M.A. (2000). Health care needs of children in the foster care system. *Pediatrics*, *106*, 909-918. doi:

- 10.1542/peds.106.1.59
- Simms, M.D., & Halfon, N. (1994). The health care needs of children in foster care: a research agenda. *Child Welfare, 73*, 505-24. doi: 10.1016/0145-2134(87)90034-2
- Smith, M.D.M., Jennings, L., & Lakhan, S. (2014). International education and service learning: Approaches toward cultural competency and social justice. *The Counseling Psychologist, 42*, 1188-1214. doi: 10.1177/0011000014557499
- Sroufe, A. (1995). *Emotional development: The organization of emotional life in the early years*. New York, NY: Cambridge.
- Stovall, K.C., & Dozier, M. (2000). The development of attachment in new relationships: Single subject analyses for 10 foster infants. *Development and Psychopathology, 12*, 133-156. doi: 10.1017/s0954579400002029
- Susser, E.S., Lin, S.P., & Conover, S.A. (1991). Risk factors for homelessness among patients admitted to a state mental hospital. *American Journal of Psychiatry, 148*, 1659-1664. doi: 10.1176/ajp.148.12.1659
- Takayama, J.I., Bergman, A.B., Connell, F.A. (1994). Children in foster care in the state of Washington: Health care utilization and expenditures. *Journal of the American Medical Association, 271*, 1850-1855. doi: 10.1001/jama.271.23.1850
- Teyber, E. (2000). *Interpersonal process in psychotherapy: A relational approach* (4th ed.). Stanford, CA: Thomson Learning.
- U.S. Department of Health and Human Services. (1999). *Title IV-E Independent Living Programs: A decade in review*. Washington, DC: Author.
- U.S. Department of Health and Human Services (2013a). *The AFCARS report: Preliminary FY2012 estimates as of July 2013*. Retrieved from <http://www.acf.hhs.gov/programs/cb/resource/afcars-report-20>
- U.S. Department of Health and Human Services (2013b). *Foster care statistics 2012*. Retrieved from <https://www.childwelfare.gov/pubs/factsheets/foster.pdf>
- Weisz, J.R., & Kazdin, A.E. (2010). *Evidence-based psychotherapies for children and adolescents, Second Edition*. New York, NY: Guilford.
- Yancey, A. (1992). Identity formation and social maladaptation in foster adolescents. *Adolescence, 27*, 819-831. doi: 10.1016/0140-1971(92)90046-8

# The 2014 ACA Code of Ethics: What's New, What's the Same, and What Matters for Practicing Counselors

Charles J. Jacob, Gregory Roth, Brittany Cilento, and Jessica Stoler

The American Counseling Association's Code of Ethics is seen as an evolving document that requires periodic revisions so that it may meet clients' needs in a changing society. The 2014 revision contains notable changes including: an expansion of the preamble, a stronger prohibition against imposing one's values onto clients and a newly created section fully dedicated to the use of technology. The purpose of this paper is to provide an overview of important updates for practicing counselors. Additionally, an ethical decision-making model is proposed and case examples are used to demonstrate application of the code's current iteration.

*Keywords:* Ethics, professional development, ethical decision-making

Adjustments to the code of ethics for the American Counseling Association (ACA) are required periodically to adapt to the ever-changing landscape of American culture. The 2014 update to the ACA Code of Ethics is the first substantive change to the ethical guidelines for counselors in almost a decade (the last revision was in 2005), with myriad cultural changes and precedent setting cases (Rudrow, 2012; 2013a, 2013b) taking place in the years between. While important guidelines remain the same relative to areas such as client-counselor intimacy (ACA, 2014), the influx of technological advances in recent years has created an entirely new dialogue regarding the ethics of counseling practice (Sude, 2013). The purpose of this paper is to provide a basic overview of the updates and changes to the code, with case examples to help illustrate ethical decision-making. A brief description of an ethical decision-making model developed by the authors follows an overview of changes to each section of the code, as counselors are expected to make use of such models in their clinical practice. Counselors are encouraged to use this paper as a general guide, but should reference the ethical code directly for additional clarity regarding specific standards.

## Revisions to the Code

### The Process of Revision

The seeds of the 2014 code were planted in the early 1960s, with the American Personnel and Guidance Association's (1961) five-page document, simply titled: Ethical Standards. As the name suggests, this document's purpose was to provide a formalized outline of expected professional behaviors. While notably shorter than the current version, the structure and content of this seminal work are not dissimilar from the 2014 code. For example, the 1961 Standards indicated that professionals should base their practices upon well-researched interventions, should hold clients' well-being as the primary concern, and should seek out ongoing education to maintain competence.

According to Linde (2014), the ACA's governing council has worked to revise the code every 7 - 10 years. A special committee spearheaded the process: the Ethics Revision Task Force. The most recent task force, assembled in 2011, was comprised of counselors, educators, and researchers who solicited feedback from

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a wide variety of stakeholders (Kaplan & Martz, 2014). Thousands of hours of work went into compiling and considering the feedback, creating revisions, disseminating the drafts, gathering comments on the revisions, and crafting a final version of the document (Kaplan & Martz). The resultant code debuted in early 2014. What follows is an overview of changes and updates to each section.

### The Preamble

The preamble is an integral section of the document, setting the tone, providing context, and, importantly, explaining what the counseling profession is built upon. This last point is a significant revision within the 2014 edition, as for the first time the code includes an explicit statement about the basic principles and values that undergird the profession. This introductory overview highlights that professional counselors embrace diversity, promote social justice, and enhance the personal development of those served. Additionally, this section names and defines autonomy, non-maleficence, beneficence, justice, fidelity, and veracity, along with other core values that must guide ethical behaviors.

The 2014 preamble also provides introductions of several other changes found in its subsequent sections. It establishes the idea that counselors, when faced with ethical dilemmas, must employ a formalized problem-solving model. This inclusion draws attention to the need for counselors' thoroughness when working to resolve ethical issues. Furthermore, the preamble provides a new declaration that the code of ethics is not to be mistaken for the law, in that ethical breaches are not necessarily violations of state or national regulations.

### Section A: The Counseling Relationship

This section focuses on ethical guidelines related to the client's well-being as it relates to actions of the counselor potentially affecting the therapeutic relationship. Changes to this section were mostly related to counselor's behaviors and relationships with clients outside the context of counseling sessions. For example, the language regarding standards related to sexual intimacies with present and former clients has not changed; however, a clearer prohibition of counselors working with their own friends and family was added, with the rationale that this mars objectivity. In concordance with the new section on technology, there is now a statement that explicitly prohibits social

media relationships (e.g., Facebook friendship) with current clients. Extensions of boundaries are still permitted when it is determined to be in the client's best interest (e.g., attending client weddings, funerals, etc.), though there is now specific language indicating that the counselor is required to document the rationale for doing so in advance. There is now a clear ban against counselors giving or receiving remuneration in exchange for new clients as this practice could open the door to counselor-benefited behavior rather than client-focused practices (A.10.b.).

Referrals to another counselor as a result of the personal values of the current counselor are now strongly discouraged (A.11.b.), as there is greater emphasis on attending to the needs of the client. The new code indicates that clients deemed by the counselor to be personally challenging based on his or her own value system (e.g., a pro-choice counselor working with a pro-life client) should ideally not be referred. Instead, it is the responsibility of the counselor to seek out supervision, education, and support to ensure that the client receives appropriate services. In line with this idea, the code strongly discourages counselors from referring out clients with terminal illnesses.

### Section B: Confidentiality and Privacy

The most significant change made to Section B was that the specifics of end of life decisions were moved from Section A and put in this section under Exceptions. Under this new category, the code specifically identifies that counselors have the option to maintain confidentiality, if and when they learn that a client with a terminal illness is planning to hasten his or her own death depending on applicable laws and the specifics of the situation (B.2.b.). The counselor must also seek consultation or supervision prior to deciding whether or not to keep confidentiality. However, 46 states, including Pennsylvania, have laws in place that criminalize soliciting, aiding or abetting suicide, which makes it unlikely that this would be possible (Pennsylvania Crimes Code, 2014). Additional changes include adjustments to wording to account for the inclusion and acceptance of technology. For example, under *Confidentiality of Records*, which is now entitled *Confidentiality of Records and Documentation*, the code addresses storage of documents kept in any medium.

### Section C: Professional Responsibility

Counselor incapacitation, death, retirement, or

termination of practice now applies to the retirement population. Within the 2005 Code of Ethics there were no specific ordinance that applied to professionals who retired. According to the 2014 Code, counselors must prepare a plan for transfer of clients and records to an identified colleague or records custodian prior to retirement (C.2.h.).

It is now indicated that a counselor's techniques and procedures must be grounded in scientific theory and have an empirical or scientific foundation (C.7.a.). When counselors are using a new technique, they must be aware of (and make the client aware of) the potential benefits and ethical considerations along with possible risks and harms of the technique or procedure (C.7.b.). It is also indicated that counselors are not to use any technique, procedure, or practice that may cause harm, even if the practice or procedure is requested (C.7.c.).

#### Section D: Relationships with Other Professionals and Section E: Evaluation, Assessment, and Interpretation

Changes in these sections were limited, and focused mostly on rewording to align with any changes found in other sections. As an example, standard D.1.a. now includes the phrasing "grounded in theory and/or have an empirical or scientific foundation" so that the ideas expressed in the changes to C.7.b. are reinforced.

#### Section F: Supervision, Training, and Teaching

Throughout this section, many changes were made to account for the inclusion of technological advancements in different areas. For instance, it is still unacceptable for current supervisors to have sexual relations with their supervisees, but it is now made clear that this is also unacceptable in the case of online supervision (F.3.b.). The section on informed consent and client rights now includes reference to making the client aware of how records will be stored and transmitted. Supervisors are now required to be competent in any technology they employ (F.2.c.) and ensure that they take the necessary precautions to protect confidentiality electronically (though specifics of what these precautions might entail are not outlined).

The 2005 code addressed the need to remain objective in supervision and stated that supervisors should avoid entering into supervisory roles with friends or family for this reason (F.3.d.). The 2014 version takes a stronger stance, stating that this is prohibited. It is also stated that counselor educators are

to only provide instruction within their areas of knowledge and competence and lessons should be based on current information (F.7.b.). Regarding case examples in the classroom, the new code specifies that either the person in the case example has agreed to its presentation or the identifying characteristics have been sufficiently obscured (F.7.f.).

#### Section G: Research and Publication

Regarding confidentiality of participants, the updated code again emphasizes the importance of researcher responsibility. However, the code does not state specific protocols based on ACA-determined guidelines. Instead, it is indicated that researchers abide by "state, federal, agency, or institutional policies or applicable guidelines" (G.1.a.) with regard to research practices. Regarding student publication, there is a new requirement that student researchers be listed as a lead author (G.1.f.) rather than just a principle author when publishing research based on their work (e.g., dissertations, theses, or class papers).

#### Section H: Distance Counseling, Technology, and Social Media

This section is entirely new, reflecting the increase in technological advances since 2005, particularly Internet-based counseling services (i.e., video or text-based services between a counselor and a client in two separate locations). Standard H.1.b. highlights that counselors are subject to laws and regulations in both the areas in which they are practicing and in which the client resides. There is not, however, any directive for how to address discrepancies between the two (presumably, the more stringent of the two is to be enforced). Informed consent is more heavily weighted in this type of counseling than in face-to-face services, with the expectation that clients be made aware of all practical limitations of Internet-based services, including methods for managing technological breakdowns as well as limitations of confidentiality (H.2.a.). Client verification is stressed as well; if a counselor is using text-based messaging systems or some related equivalent, he or she should develop a code word or passcode to verify the client's identity. It is also recommended that counselors ensure the client is aware of the miscommunications that can happen in this approach (e.g., emotions such as sarcasm may be difficult to detect in text).

Regarding electronic records, specific standards enforced by ACA are limited. The code again indicates

that counselors are at the behest any laws to determine what constitutes effective electronic record-keeping (H.5.a.). Additionally, H.5.a. notes that counselors must inform clients as to how records are stored and maintained (e.g., type of encryption used).

This is the first time that web presence of the counselor is mentioned in the code (H.6.a.). It is stated that if a counselor has a personal website or uses social media (e.g., Facebook, Twitter), there are now guidelines that must be followed. Specifically, if a counselor uses a website for promotional purposes, it should provide electronic links to licensure and/or certification boards. These links must be updated (H.5.a.) and the website should be accessible to individuals with disabilities (H.5.d.). Counselors are free to have personal, social, and professional webpages and social media pages, but they need to be separate and distinguishable. Additionally, standard H.6.b. prohibits counselors from searching social media or

other webpages for client information without the client’s consent (i.e., it is unethical to Google a client or to view their Facebook page).

### Section I: Resolving Ethical Issues

The importance of enacting an ethical decision making model is noted both in Section I as well as the Preamble. No one model is endorsed, but counselors are expected to use a delineated process to resolve dilemmas and to accurately keep records of the steps used. Additionally, this section adds new details as to how counselors should respond when confronted with irresolvable conflicts between ethics and laws. In such situations, section I.1.c. notes that counselors should be clear in their efforts to honor the code of ethics and work toward the best resolution for clients, while also providing counselors the option to adhere to all local, state and federal laws.

**Table 1**

**Highlights of the 2014 ACA Code of Ethics**

Section	Highlights
<b>Section A: The Counseling Relationship</b>	<ul style="list-style-type: none"> <li>• Referrals based on personal values are now discouraged</li> </ul>
<b>Section B: Confidentiality and Privacy</b>	<ul style="list-style-type: none"> <li>• Counselors have the option to maintain confidentiality, if and when they learn that a client with a terminal illness is planning to hasten his or her own death</li> </ul>
<b>Section C: Professional Responsibility</b>	<ul style="list-style-type: none"> <li>• Counselor incapacitation, death, or termination of practice now also applies to retirees</li> <li>• Counselor techniques and procedures must be grounded in scientific theory and have an empirical or scientific foundation</li> </ul>
<b>Section D: Relationships with Other Professionals</b>	<ul style="list-style-type: none"> <li>• Changes focused mostly on rewording for clarity</li> </ul>
<b>Section E: Evaluation, Assessment, and Interpretation</b>	<ul style="list-style-type: none"> <li>• Changes focused mostly on rewording for clarity</li> </ul>
<b>Section F: Supervision, Training, and Teaching</b>	<ul style="list-style-type: none"> <li>• Sexual relationships with supervisees are inappropriate, including online supervision</li> <li>• Supervisors are now required to ensure that they take the precautions to protect confidentiality electronically</li> <li>• Supervisory roles with friends or family are prohibited</li> </ul>
<b>Section G: Research and Publication</b>	<ul style="list-style-type: none"> <li>• Student researchers should be listed as a lead author rather than just a principle author when publishing research based on their work</li> </ul>
<b>Section H: Distance Counseling, Technology, and Social Media</b>	<ul style="list-style-type: none"> <li>• Section is entirely new</li> <li>• For distance counseling, counselors are subject to laws and regulations in both the areas in which they are practicing in <i>and</i> in which the client resides.</li> <li>• Counselors need to have distinct and separate personal and professional webpages and social media</li> <li>• Internet searching a client without consent is prohibited</li> </ul>
<b>Section I: Resolving Ethical Issues</b>	<ul style="list-style-type: none"> <li>• Counselors are now required to employ an ethical decision-making model.</li> </ul>

## A Proposed Ethical Decision-Making Model

Per the most recent updates to the model, counselors are expected to make use of ethical decision-making models in their clinical practice, though no specific model is endorsed as the standard. The following step-by-step procedure was developed by the authors, and pulls from Cottone and Claus' (2000) overview as well as Garcia, Cartwright, Winston, and Borzuchowska's (2003) transcultural model. While clinical acumen should not be discounted in the process of counseling, the hope is that counselors will follow these steps and be thoughtful as well as intentional in their actions.

1. In advance of ethical dilemmas, be aware of bias hotspots. Counselors should know themselves and know where their potential weaknesses regarding ethical decision-making may occur. Counselors benefit from awareness (i.e., mindful attention to internal processes) in session both with regard to personal wellness and alliance building with clients (Fauth & Nutt-Williams, 2005).
2. When presented with an ethical dilemma, practice mindful awareness. In the interest of reducing bias in decision-making, counselors should be aware of emotions while making an effort to remain unattached to them. Mindfulness-based training programs and continued practice have demonstrated both long and short-term benefits for practicing counselors (Christopher et al., 2010).
3. Reference the code of ethics, either mentally or by keeping a hard or soft copy to access as needed. Regardless, counselors should be aware of the basic principles enough so that they are memorized.
4. When making a decision, take time to consider alternative options. Decision-making research suggests that complicated choices can be influenced by bias (Hays, McLeod, & Prosek, 2009), and that counselors are more inclined to ask confirmatory questions than questions that may disconfirm their existing hypotheses. For example, counselors looking to assign a

diagnosis to a client are more likely to seek support for their initial assessment than to explore alternative diagnoses (Owen, 2008). As such, counselors faced with ethical dilemmas should make a concerted effort to play devil's advocate and consider alternate ideas.

5. Consult with peers as needed. Decision-making relative to complex ethical concerns should not occur in isolation. Counselors should make sure, however, that they are consulting with a fellow clinician or supervisor and that the person will be supportive and challenging as needed (as opposed to just validating the actions and concerns of the counselor).

## Case Examples

### David and Conversion Therapy

*Imagine that you are a counselor who is trained in cognitive behavioral therapy (CBT) whom is working at a community mental health clinic in rural area. Most of your clients – in step with the cultural norms of the area – are deeply religious and conservative.*

*David, a young man in his early 20s, begins seeing you for counseling to address depression and anxiety, but soon admits to his actual intentions for attending counseling. Specifically, he identifies as gay, but says that he would like to receive CBT to help address his homosexual urges. He states that he is aware of the risks, but is intent on receiving treatment to “correct this problem.” He says that if you are unwilling to help him, he has found a pastor in the area that is willing to provide conversion therapy, a faith-based approach that he believes will cure him of his attraction to the same sex.*

*What is the best course of action? How will you help David?*

Clearly, using CBT as a variant of conversion therapy is unethical. CBT is supported by research as an effective treatment of depression and anxiety (Beck, 2011), but there is no research to suggest that it can be used to change sexual orientation. Additionally, conversion therapy is a controversial treatment that has been banned for clients under the age of 18 in both New Jersey and California (Rudrow, 2013). The fact that David will receive this treatment if the counselor opts not to provide it is not the primary ethical concern;

however, the counselor may see this as a moral one, out of fear that the client may seek out a potentially harmful treatment if the counselor does not intervene. Section C of the new code states that counselors' interventions must be grounded in scientific theory and have an empirical or scientific foundation, but does not include any language requiring counselors to prevent the client from deciding his or her own course of treatment. The counselor should, however, provide as much current information related to available treatments and encourage David to make the best choice on his own.

### Mary and Terminal Illness

*Imagine that you are a counselor working in private practice. Your current client – Mary, a woman in her mid-20s – has been seeing you for 6 months following a diagnosis of terminal brain cancer. The focus of treatment has been managing her anxiety, as she has been given about 6 months to live by her treating physicians. They anticipate that her physical discomfort will become intense and dramatic as the illness progresses.*

*During today's session, Mary indicates that she has felt an alleviation of her anxiety since she was able to obtain a lethal amount of painkillers. The medicine was obtained legally through her physician. Upon further questioning, she says that she is likely going to overdose by the end of the summer, as she anticipates that "this will be when things get unbearable."*

*What is the best course of action? How will you help Mary?*

The new code indicates that maintaining confidentiality is an option when clients with terminal illnesses are considering taking their own lives (B.2.b.), but counselors also need to consider applicable laws. According to the Pennsylvania Crimes Code (2014), a person who intentionally aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor of the second degree (Pennsylvania Crimes Code). An important consideration in this situation is whether the counselor could be considered culpable or complicit in the person's death. Assuming complicit, confidentiality may be possible; assuming not, the counselor might be in serious legal trouble. In either case, the counselor should consult with a supervisor or other colleague first, and may also benefit from consultation with a lawyer. Counselors should work to empower clients when confronted by difficult decisions related to

terminal illnesses, but refraining from legal sanctions should be a goal as well.

### The ACA and FERPA

*Imagine you are a counselor working in a college counseling center. Your college is a smaller institution, and is just now beginning to implement a system for electronic record keeping. As part of the implementation, administration is establishing who can have access to counseling records. The director of student health services has indicated that counseling records should be available to all medical personnel, and cites a regulation within the Family Educational Rights and Privacy Act (FERPA) that indicates this is acceptable.*

*What is the best course of action? How do you respond when the code of ethics is in conflict with the code of the institution?*

The updated code indicates that, in cases where ethics of the profession conflict with the law or other governing legal authority, counselors are obligated to make clear their commitment to the code of ethics and take steps to resolve the conflict (I.1.c.). In this case, the counselor may need to make clear to the institution what is and is not acceptable on behalf of the counseling profession. The counselor should inform the college's administration of the conflict with the code of ethics, and work to establish a possible resolution. In this case, the ideal outcome for counselors would be for no one outside of the counseling center's staff to have access to students' mental health records.

However, conflicts between FERPA and the Health Insurance Portability and Accountability Act (HIPAA) may provide an overview for how to resolve this issue. FERPA states that in cases where health services are provided to students under contract with the school, the records are considered to be education records under FERPA. While counseling services through the school's counseling center are not covered by health insurance (and thus not subject to HIPAA), this creates a precedent under which the school may have the legal right to make counseling records available to medical personnel.

### Client Emails

*Imagine you are a counselor in private practice. As part of your marketing for your business, you keep a website that advertises – among other things – your work email address. Clients regularly use this email*

address to contact you about scheduling, though some make a point of sending you treatment-related concerns. One client in particular regularly emails you following sessions, despite the fact that you have made (and documented) numerous efforts to establish appropriate boundaries.

*In writing a response to your client, you accidentally include one of your colleagues as a message recipient. This means that you have accidentally forwarded your client's name, email address, and pertinent clinical information to an unapproved recipient.*

*How do you respond in this case? What steps can be taken to prevent problems such as this in the future?*

The concern in this case is whether or not appropriate steps were taken in advance to ensure that the client understood the limits of confidentiality via email (H.2.b., H.2.d., H.4.f.). Emails are – in theory – treated the same as any other client-counselor communication in that confidentiality abides with certain exceptions (e.g., suicidal threats, supervision, etc.). However, email, texts, and voicemail cannot be afforded the same guarantees as face-to-face contact in session due to the lack of security measures beyond simply password protecting an email account. In the case of emails, counselors should make clear in advance that while they have no intention of sharing client communications, they can offer no guarantees once a message has been sent via the Internet.

## Conclusion

By its nature, the code cannot remain a static document. It needs to be updated to reflect the current knowledge and improvements that are occurring within the profession, while also meeting the changing needs and expectations of society. This overview is intended as a general guideline detailing specific changes between the ACA 2005 Code of Ethics and the ACA 2014 version of the code. This article is not a substitute for independent review of the updated code, and the authors encourage practicing clinicians to carefully read the 2014 edition.

## References

American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.

American Counseling Association (2014). *ACA code of ethics*. Alexandria, VA: Author.

American Personnel and Guidance Association. (1961). *Ethical standards*. Washington, D.C.: Author

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2<sup>nd</sup> ed.). New York: The Guilford Press.

Christopher, J. C., Chrisman, J. A., Trotter-Mathison, M. J., Schure, M. B., Dahlen, P., Christopher, S. B. (2010). Perceptions of the long-term influence of mindfulness training on counselors and psychotherapists: A qualitative inquiry. *Journal of Humanistic Psychology, 51*, 318-349. doi:10.1177/0022167810381471

Cottone, R. R. & Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling and Development, 78*(3), 275-283. doi: 10.1002/j.1556-6676.2000.tb01908.x

Family Educational Rights and Privacy Act, as amended. Codified at 20 U.S.C. §1232g.

Fauth, J. & Nutt-Williams, E. (2005). The in-session self-awareness of therapist-trainees: Hindering or helpful? *Journal of Counseling Psychology, 52*(3), 443-447. doi: 10.1037/0022-0167.52.3.443

Garcia, J. G., Cartwright, B., Winston, S. M., & Borzuchowska, B. (2003). A transcultural integrative model for ethical decision making in counseling. *Journal of Counseling and Development, 81*(3), 268-277. doi: 10.1002/j.1556-6678.2003.tb00253.x

Hays, D. G., McLeod, A. L., & Prosek, E. (2009). Diagnostic variance among counselors and counselor trainees. *Measurement and Evaluation in Counseling and Development, 42*(3), 3-14. doi: 10.1177/0748175609333559

Kaplan, D. & Martz, E. (2014, July). An overview of the revised ACA code of ethics. *Counseling Today*, 20-21. Retrieved from: <http://www.counseling.org/docs/default-source/ethics/2014-code-of-ethics-overview.pdf?sfvrsn=0>

Linde, L. E. (Speaker). (2014). *The new ACA code of ethics: An overview* [Audio Podcast]. Retrieved from: <http://www.counseling.org/knowledge-center/podcasts/docs/default-source/acapodcasts/ht043--the-new-2014-code-of-ethics-an-overview>

Owen, J. (2008). The nature of confirmatory strategies in the initial assessment process. *Journal of Mental Health Counseling, 30*(4), 362-374.

Pennsylvania Crimes Code, 18 Pa. C. S. §2505 (2014).

Rudrow, H. (2013a, January 9). Resolution of EMU case confirms ACA code of ethics, counseling profession's stance against client discrimination. *Counseling Today*. Retrieved from: <http://ct.counseling.org/2013/01/resolution-of-emu->

## Updates to the ACA Code of Ethics

caseconfirms-aca-code-of-ethics-counseling-professions-stance-against-client-discrimination/

Rudrow, H. (2013b, August 20). Ban on reparative therapy signed in New Jersey. *Counseling Today*.

Retrieved from: <http://ct.counseling.org/2013/08/ban-on-reparative-therapy-signed-in-new-jersey/>

Rudrow, H. (2012, June 28). Judge throws out counseling student's suit against Augusta State. *Counseling Today*.

Retrieved from: <http://ct.counseling.org/2012/06/judge-throws-out-counseling-students-suit-against-augusta-state/>

Sude, M. E. (2013). Text messaging and private practice: Ethical challenges and guidelines for developing personal best practices. *Journal of Mental Health Counseling*, 35(3), 211-227.

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## **PENNSYLVANIA ASSOCIATION OF SPECIALISTS IN GROUP WORK**

The Pennsylvania Association of Specialists in Group Work is looking to fill a vacancy in the position of Division Chair. Interested members should contact PCA President, Paul Datti.

# Bulletin Board

## **SOCIAL MEDIA AND ADVERTISING COMMITTEE**

Members are needed to serve on the Social Media and Advertising Committee. Interested members are asked to contact Abby Dougherty at [abby.dougherty@rosemont.edu](mailto:abby.dougherty@rosemont.edu).

## **NORTHEAST PENNSYLVANIA COUNSELING ASSOCIATION**

The Northeast Pennsylvania Counseling Association is looking to fill a vacancy in the position of Committee Chair. Interested members should contact PCA President, Paul Datti.

## **GOVERNMENT RELATIONS**

One of the Pennsylvania Counseling Association's primary objectives is to lobby state legislators and administration officials in Harrisburg for laws and policies that are favorable to professional counselors and the clients that they serve. A recent and significant example of that is Act 136, Pennsylvania's LCSW/LPC law. PCA is also committed to opposing legislation that has the potential to negatively affect counselors in our state. Despite many accomplishments so far, many other legislative battles and advocacy initiatives need to be waged. To learn how you can help, contact the PCA Government Relations Committee at [PCAGovernmentRelations@gmail.com](mailto:PCAGovernmentRelations@gmail.com).

## **GREATER PHILADELPHIA COUNSELING ASSOCIATION**

Planning & Development Meeting  
Saturday, June 20, 2015  
10:00 AM – 12:00 PM  
Holy Family University  
One Campus Drive, Newtown, PA 18940  
Free Parking - Meeting in Cafeteria

We are so excited by the enthusiastic response to our invitation to become a part of a newly constituted networking group in the Philadelphia region. The purpose of this first meeting is to bring you up-to-date regarding our status with the PA Counseling Association and to invite you to brainstorm with us regarding our future. Please RSVP to Acting President, Minna Davis ([MinnaDavis1@gmail.com](mailto:MinnaDavis1@gmail.com)), Acting President-elect, Marta Smith ([martasmith02@gmail.com](mailto:martasmith02@gmail.com)), or Acting Treasurer, Mark Kenney ([markekenney@comcast.net](mailto:markekenney@comcast.net)) to let us know that you will be attending.

## **COMING SOON!!!!**

Earn CE credit for reading JPCA articles beginning with Volume 14, Number 2, Fall 2015.

# Guidelines for Authors

The *Journal of the Pennsylvania Counseling Association (JPCA)* is a professional, refereed journal dedicated to the study and development of the counseling profession. The Editor invites scholarly articles based on existing literature that address the interest, theory, research, and innovative programs and practices of professional counselors. Authors submitting manuscripts to the journal should not simultaneously submit them to another journal, nor should manuscripts have been published elsewhere in substantially similar form or with substantially similar content. All submissions are blind peer reviewed and authors should expect a decision regarding a manuscript within three months of acknowledgement of receipt. Following are guidelines for developing and submitting a manuscript. Any submissions that do not adhere to the following guidelines will be returned without review.

## Specific Requirements

1. Manuscripts should not exceed 25 pages, including references.
2. Manuscripts should be typewritten, double-spaced (including references and extensive quotations) with 1" margins on all sides.
3. **Title Page:** Identify the title page with a running head. The title page should include title (not more than 80 characters), author, affiliation, and an author's note with contact information. Author's note should be formatted exactly as it appears in this example:

Author Name, Department of \_\_\_\_\_, University Name [or Company affiliation].  
Correspondence concerning this article should be addressed to Author Name, Department of \_\_\_\_\_,  
University, Street address, City, State, zip code (e-mail: xxxxx@xxx.edu).
4. **Abstract:** Begin the abstract on a new page, and identify the abstract page with the running head and the number 2 typed in the upper right-hand header of the page. The abstract should not exceed 75 words.
5. **Keywords:** Keywords should follow the abstract on page 2 and are limited to 5 words.
6. **Text:** Begin the text on a page 3, and identify the text page with the running head and page number 3 typed in the upper right-hand header of the page. Type the title of the article centered at the top of the page and then type the text. Each subsequent page of the text should carry the running head and page number.
7. **Tables and Figures:** No more than 3 tables and 2 figures with each manuscript will be accepted. Do not embed tables or figures within the body of the manuscript. Each table or figure should be placed on a separate page following the reference list
8. **References:** References should follow the style detailed in the APA Publication Manual. Check all references for completeness, including the year, volume number, and pages for journal citations. Please be sure to include DOI numbers as necessary. Make sure that all references mentioned in the text are listed in the reference section and vice versa and that the spelling of author names and years are consistent.
9. **Footnotes or endnotes:** Do not use. Please incorporate any information within the body of the manuscript.
10. **Other:** Authors must also carefully follow APA Publication Manual guidelines for nondiscriminatory language regarding gender, sexual orientation, racial and ethnic identity, disabilities, and age. In addition, the terms counseling, counselor, and client are preferred, rather than their many synonyms.
11. In addition to the specific requirements of the JPCA, authors will adhere to all requirements of the *Publication Manual of the American Psychological Association (6<sup>th</sup> ed.)*.
12. An electronic copy of the manuscript should be e-mailed to the editor: Dr. Richard Joseph Behun (pcajournal@gmail.com).

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PENNSYLVANIA COUNSELING  
ASSOCIATION

*A Branch of the American Counseling Association*

The 47<sup>th</sup> Annual

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