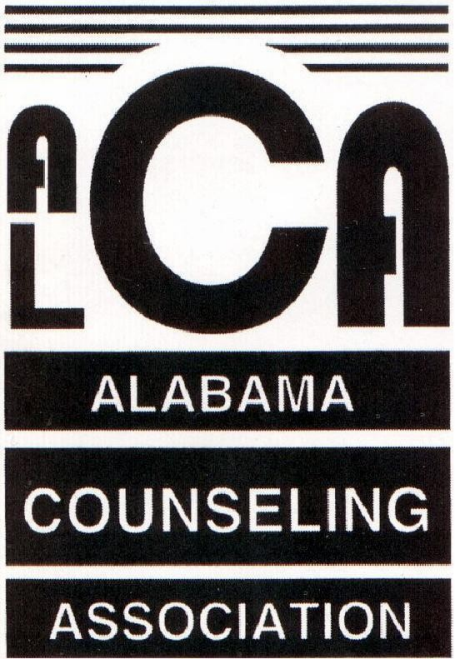
The Alabama Counseling Association Journal, Volume 36, Number 1

The Alabama Counseling Association

JOURNAL



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The Alabama Counseling Association Journal, Volume 36, Number 1

Letter From the Editor

What Have We Learned from Augusta State University?

During this past summer, an Augusta State University Counselor Education student faced remediation from the Counselor Education Program because she refused to silence her convictions on homosexuality and gender identity.

According to the Chronicle of Higher Education (July 22, 2010) Ms. Keeton argued faculty members and administrators at the university violated her First Amendment rights to free speech and the free exercise of religion by threatening her with expulsion if she did not fulfill requirements contained in a remediation plan intended to get her to change her beliefs.

Ms. Jennifer Keeton allegedly voiced her biblical views and Christian beliefs regarding homosexuality and gender identity both inside and outside the classroom, prompting the Augusta State University Counselor Education Program to issue a remediation plan after Ms. Keeton wrote a term paper regarding the gay, lesbian, bisexual and transgender, or GLBT, community stating "It would be hard (for her) to work with this population." Ms. Keeton also allegedly told a classmate she would "tell gay clients their behavior is morally wrong and then help the client change that behavior."

Ms. Keeton's filed a lawsuit against Augusta State University accusing the university of being ideologically heavy-handed in imposing the requirements on her simply because she has communicated both inside and outside the classroom that she holds to Christian ethical convictions on matters of human sexuality and gender identity. It argues her views, which hold homosexual behavior is immoral and homosexuality is a chosen lifestyle, would not interfere with her ability to provide competent counseling to gay men and lesbians.

The lawsuit stated Augusta State faculty members developed a remediation plan specifically for Ms. Keeton and told her she would be expelled from the College of Education's Counselor Education Program if she did not fulfill its requirements. The plan called on Ms. Keeton to attend workshops on serving diverse populations, read articles on counseling gay, lesbian, and bisexual and transgendered people, and write reports to an adviser summarizing what she has learned. It also instructed her to work to increase her exposure to, and interaction with, gay populations, and suggested that she attend the local gay-pride parade (Chronicle of Higher Education, July 22. 2010).

In August, a federal judge ruled Augusta State University's requirement that a graduate student read material about counseling gays and increase her exposure to that community after she objected to counseling homosexual clients was academically legitimate, (The Augusta Chronicle, November 14, 2010). This ruling is similar to a ruling in Michigan where a federal judge dismissed a lawsuit filed against Eastern Michigan University by a student who was kicked out of its graduate program in school counseling last year for refusing, on religious grounds, to affirm homosexual behavior in serving clients (Chronicle of Higher Education, July 27, 2010).

What can we learn from such incidents, which are unfortunate for all concerned? In following the Augusta State University story, it appears much could have been done that might have prevented such events from unfolding.

Michael P. Chaney, Ph.D., President of the Association of Lesbian, Gay, Bisexual, & Transgender Issues in Counseling stated, "Although there are no clear cut answers when certain religious beliefs conflict with queer

issues, what is currently happening with a counseling student at Augusta State University provides us an opportunity to have important and necessary discussions about culturally competent counselor training and dialogues about social injustices toward lesbian, gay, bisexual, transgender, queer/questioning, intersex, and ally (LGBTQQIA) communities. It is pertinent that these discussions remain ongoing and not just during the initial discovery of the controversial event. Therefore, it is our hope that the counseling profession will take steps to rally together to create safe spaces for these difficult dialogues to take place, for all individuals involved." (http://www.aglbical.org/2A%20NEWS%20(CURRENT).htm. Retrieved November 14, 2010.)

So, what can we learn from such events? Here are some specific ideas:

1. Counselor Education Programs should look at their printed and electronic materials to determine if and how diversity issues are communicated. Such information should reflect the American Counseling Association's (ACA) Code of Ethics.
2. Counselor Education Programs should consider conducting interviews as part of their admission process. Prior to participating in an interview, the ACA Code of Ethics should be sent to each interviewee to read. The interviewee should answer questions regarding what they agree or disagree with pertaining to diversity issues covered in the ACA Code of Ethics.
3. Counselor Education Programs should conduct an orientation with new students prior to the beginning of classes. Along with becoming familiar with the specifics of the program, the orientation should serve as an opportunity for admitees to sign their "informed consent" forms acknowledging knowledge of program requirements while also agreeing to adhere to the ACA Code of Ethics.
4. Discussions should be integrated regarding diversity and pluralism throughout a student's program of study both in and out of class. Counselor Education Programs should provide ongoing professional development opportunities outside of the classroom for students to engage in dialogue, hear opposing points of view, and to have the opportunity for continual reflection of how one's personal views mirror ACA's Code of Ethics.
5. Program faculty must model adherence to ACA's Code of Ethics. Modeling such behavior should occur both in and outside of classroom situations, in both formal and informal environments.

There may be other ideas, which have merit. It is this Editor's hope Alabama Counselor Education Programs will begin discussing such ideas.

Lawrence E. Tyson, Ph.D.

Editor

Fall 2010
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Challenges in Diagnosing and Treating Postpartum Blues, Depression and Psychosis

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Abstract

With recent media attention and a growing awareness in popular culture, the appropriate treatment for postpartum depression has taken center stage as a prevalent women's health issue. There is little agreement on the definition, existence and treatment of postpartum depression. Contributing to this factor is the lack of research that exists to support which method of counseling best treats postpartum depression. The intent of this paper is to suggest that with increased counseling and counselor involvement postpartum depression can be lessened, decreasing the length and severity of the symptoms without the use of anti-depressants

Challenges in Diagnosing and Treating Postpartum Blues, Depression and Psychosis

Despite many research studies and a growing awareness throughout the late 20th century, postpartum depression (PPD) has remained an understudied phenomenon. When Texas housewife Andrea Yates murdered her five children in 2001, PPD returned to the forefront of media attention. Yates had a history of PPD and postpartum psychosis; she was eventually found not guilty by reason of insanity (Doherty, 2007). Moreover, when actress Brooke Shields (2005a) published her memoir detailing PPD, fellow actor Tom Cruise publicly condemned her use of antidepressants. Shields fired back by defending her choice and became a vocal advocate for women seeking help with PPD (2005b). These two incidents serve as important reminders that PPD is a prevalent counseling issue, which warrants further study.

Prichard (1835) reveals that mood changes in women after childbirth have been observed for hundreds of years, yet this condition has not been adequately addressed by the counseling profession. Albright (1993) states that at least 12% of women suffer from some serious form of PPD. At issue: At what point do the symptoms of depression become critical or dangerous to the life of the mother or the child?

PPD affects a significant number of new mothers and has a negative impact on families. PPD has been shown to impair mother-infant bonding (Moehler, Brunner, Wiebel, Reck, & Resh, 2006), family relationships and social functioning (Mauthner, 1998), and even infant development (Ramchandani, Stein, Evans, O'Connor, 2005; Whitaker, Orzol, & Kahn, 2006). PPD can become disruptive or dangerous to the life of the mother and/or the life of the child.

Diagnosing Postpartum Depression

There is little agreement on the definition, existence and treatment of postpartum depression. Many factors contribute to the difficulty of diagnosing and treating the problem. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*; American Psychiatric Association [APA], 2000) classifies PPD as major depression single episode or recurrent with postpartum onset. These symptoms are considered the same as those for disorders in non postpartum women. For instance, the *DSM* formally characterizes PPD as any major depressive, manic, or mixed episode which occurs postpartum. As such, a diagnosis of PPD is determined when one experiences at least five of the nine symptoms listed for major depression at least four

weeks following childbirth. These symptoms listed in the *DSM* (2000) include the following:

- persistent depressed mood
- lessened interest in performing tasks
- considerable weight loss or gain
- oversleeping or lack of sleep
- restlessness or lack of energy
- excessive feelings of remorse
- difficulty concentrating
- preoccupation with death (pp.349-356).

New mothers may suffer from the above symptoms; however, a diagnosis of PPD cannot be given until four weeks postpartum. The common feelings of exhaustion and anxiety while adjusting to an infant's arrival coupled with a significant decline in hormone production during the initial postpartum period is considered "baby blues" (Abrams & Curran, 2007; Hendrick, Altschuler, & Suri, 1998). Since these symptoms are typical of the postpartum experience, they are not yet considered pathological.

Beck (1983) describes a client's experience of depression when one or more of these ideations is present:

A. Fatigability, crying spells, suicidal threats;
B. The underlying motivational disturbances (if any), the wish to avoid activities or to escape from life;
C. Underlying the motivation, a cluster of cognitions, such as the belief that striving toward a goal is futile, that there are no satisfactions ahead, and that he is defeated, deprived, and defective. (p. 265).

Adding to the debate surrounding symptoms, research conducted by Ugarriza (2002) discovered that mothers who self-reported symptoms of PPD often described milder or different symptoms altogether from those listed for major depressive disorder with postpartum onset in the *DSM* (APA, 2000). Curiously, the study also pointed out that health care providers cited biological factors as the cause of the mothers' symptoms, while mothers primarily attributed their symptoms to social factors or confidence, rather than hormonal or biological processes. Specific factors warranting a diagnosis of PPD include the following:

- lack of confidence in parenting skills
- complications with breastfeeding
- sleep deprivation (not sleep disorders)
- being overwhelmed by parenting responsibilities
- caesarean section delivery
- adjusting to numerous role changes
- little assistance from family or friends (pp. 227-233).

Ugarizza (2002) further observed that the depression was not persistent; instead, it came and went periodically. The two studies varied in that in Beck's study (1992) some of the participants experienced suicidal ideation, while none of Ugarriza's participants admitted to such thoughts. Similarly, a literature review (Lindahl, Pearson, & Cope, 2004) examining suicide during the postpartum period suggested that suicide was not a prevalent occurrence. While these symptoms are not exhaustive, they represent some of the problems that can occur when diagnosing PPD.

In contrast, two studies (Beck, 1992; Ugarriza, 2002) suggest different symptoms from those listed in the *DSM*. Symptoms which are not considered in the DSM-IV-TR but may contribute to the mothers' PPD include the following:

- hormonal imbalance
- conforming to new roles
- breastfeeding problems

- complicated pregnancy or delivery
- little assistance from family or friends (pp. 166-170).

Specifically, as related to PPD, these symptoms are usually recognized between two weeks and three months following birth. In addition, the symptoms of the condition tend to have a gradual onset (Ugarriza & Schmidt, 2006) and may last up to two years following birth.

Following childbirth, a large number of new mothers experience life altering mood swings. This period in a woman's life involves changes on numerous levels including hormonal, physical, emotional, social, and identity. This puerperal madness (Prichard 1835) is referred to as postpartum blues, postpartum depression or postpartum psychosis. According to the *DSM*, the prominent symptoms of postpartum condition may include depression, anxiety, extreme worry, panic attacks, short temper, irritability, moodiness, sleep problems, extreme fatigue, sadness, frequent crying, feelings of inadequacy, guilt, hopelessness and despair, not eating or eating too much, difficulty concentrating, making decisions, loss of sexual interest, persistent frightening thoughts of suicide, harm to the baby (APA, 2000).

While it is important to understand what postpartum depression is, it is just as important to understand what it is not. It lies between what is typically referred to as "baby blues" and the more severe postpartum psychosis as described in the *DSM* (APA, 2000 p. 423). The baby blues, which affects approximately 70% of new mothers, tend to be temporary and relatively harmless. Baker, Mancuso, Montenegro, & Lyons (2002) describe similar symptoms for baby blues that are also indicative of PPD: weepiness, feeling disoriented, sleeplessness, excessive worry, and unstable mood. The baby blues disappear after about fourteen days and are considered a transition into motherhood.

At the other extreme lies postpartum psychosis, a mood disorder that may be present in as many as one in 500 mothers following birth. Postpartum psychosis primarily affects women who have experienced mood disorders or postpartum mood disorders in the past. Like baby blues, it appears within the first four weeks postpartum (Lusskin, Pundiak, Habib, 2007), but affected women are often consumed with thoughts of harming the infant or even a feeling that the child is "possessed" (APA, 2000 p. 422). Mothers, families, and health care providers must understand the differences among the three when considering treatment.

The pervasiveness and etiology of PPD has remained somewhat inconsistent through the years. O'Hara and Swain (1996) conducted a meta-analysis that reviewed the prevalence of PPD without psychotic features. Their review estimated that 13% of new mothers experience PPD. Likewise, Brett, Barfield, & Williams (2008) reviewed a related study that was conducted by the Center for Disease Control in which 11% to 20% of women self-reported PPD. In this study, tobacco use, physical abuse, financial stress, trauma, and partner-related stress were also identified as possible risk factors for PPD.

In addition, young mothers, mothers with less education, and mothers receiving Medicaid were more likely to report depressive symptoms. Finally, women were most likely to experience PPD if they were a minority, of low socioeconomic status, or if they had previously experienced depression (Rich-Edwards, Kleinman, Abrams, Harlow, McLaughlin, Joffe et al., 2006).

A wide range of diagnostic standards and a variety of assessment tools have been used by different researchers, resulting in many different conclusions (Albright 1993). In a review of eight different screening instruments for PPD, the conclusion reached showed that "given the lack of consensus about the utility and psychometric properties of screening measures in both clinical and research settings, additional research is needed to determine the best measure for large-scale screening efforts for PPD symptoms" (Boyd , Le & Somberg, 2005, p. 151).

Treating Postpartum Depression

As PPD awareness grew, women were treated in a similar fashion as patients in a psychiatric ward with drugs, psychotherapy, or a combination of both (Dalton & Holton, 2001). Growing concern about the well being of new mothers prompted researchers to question the safety of this treatment. New research examined multiple

treatment methods in an effort to determine which ones were most efficacious. Common treatments for major depression such as psychotherapy, cognitive-behavior therapy, and non-directive counseling show effectiveness in treating PPD (Cooper & Murray, 1997). More recent research studying less conventional psychotherapeutic treatments such as hypnosis (Yexley, 2007), electroconvulsive therapy (Forray & Ostroff, 2007), art therapy (Perry, Thurston, & Perry, 2008), and exercise (Dritsa, Da Costa, Dupuis, Lowensteyn & Khalifé, 2008) have shown promise in relieving some symptoms of PPD.

With media attention and a growing awareness in popular culture, the appropriate treatment of PPD has taken center stage as a prevalent women's health issue. Both Milgrom, Negri, Gemmill, McNeil, & Martin (2003) and Ugarrizza & Schmidt (2006) contend that health care providers who recognize that depression exists simply prescribe an antidepressant, often without truly understanding the consequences which may arise from its use (Appleby, Warner, Whitton, & Faragher, 1997). Mothers who are reluctant to take an antidepressant may not be aware of other choices available to them. As a result, many depressed mothers do not receive treatment.

No general consensus exists among counseling professionals for treating PPD. Women have choices, such as taking antidepressants, individual or group therapy, art therapy, alternative therapies, or a combination of these, when considering treatment. However, women who breastfeed may display skepticism when prescribed antidepressants because of the undetermined effect on the infant (Pearlstein, Zlotnick, Battle, Stuart, O'Hara et al., 2006). Both cognitive-behavior therapy (CBT) and interpersonal psychotherapy (IPT) in individual or group settings have been popular choices among treatment providers (Springate & Chaudron, 2005).

Psychotropic medication use in the postpartum period is of great concern for mothers, especially those who breastfeed. At this time, there are no randomized, placebo-controlled studies for PPD to determine what, if any, long-term effects medication has on breastfeeding mothers and their infants. Apparently, all medications that pass through breast milk will be ingested by the infant, but how the infant is harmed by the medication is not always evident (Payne, 2007). Such uncertainty creates challenges in studying the effects of psychotropic medications in women that choose to breastfeed.

Even so, some researchers have studied various aspects of antidepressant use. Appleby et al., (1997) compared the use of an antidepressant and placebo with that of a cognitive-behavior therapy (CBT) group that met for either one or six sessions. They concluded that there was no clear advantage to using the antidepressant as a conjunctive treatment to the CBT therapy, and that six sessions of therapy were superior to one session.

For mothers who choose not to nurse, psychotropic medication still does not seem to be a popular choice. Pearlstein et al. (2006) studied choices of treatment among nursing and non-nursing mothers. They found that women without prior mental illness preferred psychotherapy over taking medication. In addition, they noted that women with a history of depression were more likely to prefer a medication instead of psychotherapy.

Professional intervention has been encouraged as a response to the stages of the condition where symptoms are noticeable to friends and family of the mother. The drawback is that it requires an action on the part of an already depressed mother or other family member to get the system involved. A pro-active approach would be beneficial in maintaining the barometer of normalcy. The family's community, village or town once formed a support system to remind a mother of the inevitability of these puerperal stages and to lend support. These support groups included mothers, siblings, aunts, cousins, neighbors and, grandmothers. The majority of responsibility now falls on the shoulders of counseling professionals to promote acceptance of these varying conditions as a postpartum norm requiring attention.

PPD is undeniably a distinct medical condition which warrants treatment. Despite this awareness, little research has been devoted to empirically determining the most effective methods of treatment. While many studies have examined possible treatments, much remains to be done to determine the most appropriate course of therapy.

Cognitive Behavior Therapy

When treatment appears to be the most viable option, Appleby et al., (1997), Milgrom et al. (2005), Ugarriza & Schmidt, (2006) show that cognitive behavior therapy (CBT) is an effective treatment modality. For instance, CBT has been known to be as effective as taking a prescribed antidepressant thereby providing another, perhaps even safer, option for treatment. This is a substantial finding for the mother who is apprehensive about taking an antidepressant as Appleby et al., (1997) demonstrated CBT's efficacy in six sessions when compared to an antidepressant. Another study conducted by Milgrom et al. (2005) shows promise for CBT in both individual and group settings. Participants receiving CBT showed a vast decrease in symptoms when compared to women who only received counseling from a primary care manager. This study also demonstrated that individual therapy appears to be more beneficial than group therapy. Finally, Ugarriza & Schmidt (2006) tested the plausibility of CBT along with relaxation exercises and problem solving techniques delivered over the telephone. Their basis for delivering therapy via telephone was that women who are busy tending to a newborn have time constraints which make traditional therapy inconvenient. Interestingly, the same time constraints hindered telephone therapy. Not all participants were able to complete all phases of the treatment. However, women who minimally participated in this ten-week treatment reported considerable decreases in their levels of depression. Obviously, CBT can be a sensible treatment method for women with PPD. In many cases, mental health care providers are already well-versed in delivering CBT to clients and simply employ those same techniques for mothers with PPD (Springate & Chaudron, 2005).

Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) is a brief, empirically-based psychotherapy that was initially used to treat major depression but has been adapted to treat many other mental illnesses. Practitioners of IPT focus on helping the client effectively deal with social and life events while lessening symptoms of depression. In addition, the goal is to promote autonomy independent of the therapeutic relationship (Weissman, Markowitz & Klerman, 2007).

The IPT counselor serves as an active and supportive element in the client's life. The counselor helps the client understand symptoms of the illness, and aid in problem-solving. The counselor does not determine the causes of the client's depression nor attempt to enforce drastic changes in the client's personality (Weissman, 1998).

Despite its versatility, IPT has not been extensively studied as a treatment option for PPD. Thus far, a true experimental design study that addresses IPT for PPD has yet to be published. However, completed studies have revealed that IPT for PPD is effective in both individual (O'Hara, Stuart, O'Hara, Gorman, & Wenzel, 2000; Clark, Tluczek, & Wenzel, 2003) and group settings (Klier, Muzik, Rosenblum, & Lenz, 2001; Reay, Fisher, Robertson, Adams, & Owen, 2005) and even as a preventative measure (Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001; Zlotnick, Miller, Pearlstein, Howard, & Sweeney, 2006).

Two studies have specifically studied individual IPT to treat PPD (O'Hara et al, 2000). The research design was well-planned with some limitations. First, the study was conducted with a large sample of women. A low attrition rate was maintained throughout the study. In addition, the researchers ensured that the counselors facilitating the therapy were well trained in delivering IPT. However, ten counselors facilitated the therapy, with each counselor treating a different number of clients. Also affecting the study was the fact that the women, on average, had been experiencing PPD for seven months which could have possibly biased the results. A final limitation was that participants were only qualified to participate in the study if they were married or living with a monogamous partner.

Similarly, Clark (2003) compared individual IPT with a mother-infant therapy group and a wait-list control group. Fifteen women completed treatment that was facilitated by four different counselors. In contrast to the participants in the O'Hara study, these women were likely to have had more severe depression because they were clinical patients at a psychiatric facility. As such, many still exhibited mild symptoms of depression post-

treatment. It must be noted, however, that this study contained important limitations. Foremost, many of the women assigned to the IPT group were exposed to antidepressant use which could have affected the results of the study. Second, women attending the IPT sessions frequently brought their infants to therapy and discussed parenting issues with the counselor. This was not entirely aligned with the focus of IPT, but it undoubtedly had therapeutic effects for the participants. All in all both results showed that women who participated in individual IPT reported a decline in their depressive symptoms and an improvement in their overall social functioning.

Two more studies have explored IPT in a group environment (Klier et al., 2001; Reay et al., 2005), but each study contained many limitations. Interestingly, neither study used a control group for comparison. This brings into question whether women who received no treatment would have experienced similar results. All participants in both studies were treated with IPT, but some of the participants in Reay et al., used antidepressants to supplement the IPT sessions. Therefore, it could have been possible that the antidepressant, rather than the IPT, was the therapeutic factor in treatment. Finally, both studies may have been limited by rater bias on the post-treatment assessments. Despite these limitations, IPT appeared to have therapeutic effects for women suffering from PPD.

Another variation to delivering IPT for PPD came in the development of a preventive intervention group. Zlotnick et al. (2001) developed an IPT-based intervention program aimed at preventing PPD. Both the pilot study and a larger scale study that followed (Zlotnick et al., 2006) yielded positive outcomes supporting IPT for PPD. Both studies greatly contrasted each of the other studies. To illustrate, only four sessions of the IPT -based intervention were administered to women prior to giving birth instead of the 12 suggested sessions. Additionally, the sessions functioned more as a psycho education group than as a therapy group where the women learned about parenthood, role transitions, and goal setting. A final variant to this study was in the shorter follow-up period observed in the study. This study only examined the development of PPD until the third month postpartum which could easily exclude women who develop depression late in the postpartum period.

Alternative Therapies

Recent research has focused on alternative therapies such as hypnosis, electroconvulsive, art, and exercise. First, Yexley (2007) conducted a case study in which hypnosis successfully treated the participant's self-reported depressive symptoms. A larger study may assert the claim that this treatment is effective in treating PPD. However, research concerning hypnosis and other relaxation techniques is limited.

Second, Forray and Ostroff (2007) studied the effects of electroconvulsive therapy for five women with severe PPD who had previously failed pharmacological treatments. The participants showed great improvement of their symptoms after three to six sessions. However, the use of electroconvulsive therapy to treat PPD should only be administered to those who display severe symptoms and do not respond well to other methods of therapy.

In addition, art therapy has been shown to have therapeutic effects for women with mild to moderate PPD (Perry et al., 2008). While it may not be effective for all women, research suggests that it is best used as an adjunct to medication or psychotherapy. It was difficult to find results on the efficacy of art or music therapy for reducing postpartum distress as little research has been documented. Relaxation or guided imagery was addressed in a study (Goldfried, 1974) and found to alleviate postpartum emotional difficulties and facilitate adjustment to the new maternal role.

Finally, a home-based exercise program has been shown to reduce the symptoms of mental and physical fatigue in mothers with PPD (Dritsa et al., 2008). Results of this study suggest that exercise can have a long-term impact on women with PPD. Results of three-month follow-up assessment revealed that women in the treatment group still exhibited less mental and physical fatigue when compared to those assigned to the control group.

Another alternative approach would be to institute post-partum therapy from the beginning of pregnancy as part of birthing classes or to prescribe counseling or group therapy sessions as often as the new baby sees a pediatrician. Many women refrain from telling others of their feelings because of shame, guilt or embarrassment. New mothers are expected to be happy, yet their depression escalates. Intervention is critical in helping to eliminate feelings of embarrassment or guilt with which the new mom may struggle in the absence of a required support group.

Overall, in society's current medical environment, there are few successful postpartum follow-up options. There are groups and private practices that address the subject of PPD as a legitimate condition worthy of treatment. They offer services such as screening, testing and in-home assistance (nurses, doulas and nannies), along with the prescription of readily available anti-depressants. The challenges that persist are the logistics of getting the postpartum mother to the physical location or getting the information and support to the now isolated new mother. Consequently, without further scientific research and the implementation of additional treatment alternatives, the postpartum mother is left to deal with these symptoms or the symptoms are being ignored until the situation becomes unbearable for all members of her family.

While different treatment options exist, certain options may not be suitable for every client. Women with PPD would benefit from working with a mental health care provider to determine an appropriate course of treatment. Likewise, mental health care providers have an obligation to familiarize themselves with both empirically-based treatments and emerging treatments to establish a proper treatment plan for their postpartum clients. Recommendations for further study include an investigation into whether increasing counseling for and counselor involvement for PPD can decrease the length and severity of symptoms without the use of anti-depressants.

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Scaffolding of Continuing Competency as an Essential Element of Professionalism

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Abstract

In recent years, regulatory boards have been asked to implement procedures to evaluate the competency of licensees throughout their careers, but the implementation of such competency measures is not on the immediate horizon. The responsibility for continuing competency, therefore, lies with each counselor. The work of Vygotsky is put forth as a developmental framework for conceptualizing the scaffolding of continuing competency through mentoring, supervision, consultation, professional involvement, advocacy and self care. Counselor educators and supervisors are encouraged to both model and emphasize continuing competency scaffolding elements in training and supervision

Scaffolding of Continuing Competency as an Essential Element of Professionalism

What epitomizes a proficient, therapeutically wise counselor? Most counselors could probably identify colleagues who exemplify competency. Model counselors are likely to be actively involved in professional activities, are often highly visible members of the counseling community, and are lifelong learners. They pursue increased expertise with fervor, and serve as mentors for others. Unfortunately, many counselors could also offer examples of the antithesis: that is, counselors who practice in isolation and begrudgingly attend workshops, only because they must document continuing education credit to maintain their credentials. These “anti-mentors” seem to be avoidant of authentic professional growth and development. Such counselors are stagnant in their professional growth and they can present risks to their clients. Erosion of their initial skills and competency, coupled with lack of knowledge about new developments in the counseling field, not only makes them less effective in helping their clients, but may actually lead them to cause harm.

Continuing competency is fundamental to ethical practice. The counseling profession will be best served by individuals who are intrinsically motivated to seek out lifelong learning and professional development, regardless of the existence of external regulatory requirements. Counselor educators and supervisors have an ethical responsibility to model and encourage continuing competency practices, and to promote the development of a lifelong competency plan for counselor trainees. The purpose of this article is to describe the developmental process of continuing competency and discuss competency elements that can enhance counseling expertise, thereby protecting the public from stagnant and potentially harmful practitioners. By opening discussion about continuing competency, we hope to bring to light the valuable role that counselor educators and supervisors can play in modeling and instilling the value of lifelong competency development.

Initial Competency. While members of the public may assume that credentials such as licensure and certification are reflective of a practitioner’s current level of competence, in actuality, these credentials are granted based on initial or minimal competency rather than on current knowledge and expertise (Citizen Advocacy

Center, 2004). A number of external mechanisms are in place to ensure that credentials are awarded only to counselors who are at least minimally competent. In regulation, these are commonly referred to as the "three Es:" education, examination, and experience. In general, the education component is the domain of counselor training programs which base their curricula on national standards for the training of counselors. The quality of these programs is assured through accreditation by the Council on Accreditation of Counseling and Related Educational Programs. The examination component is fulfilled through the use of the National Counselor Examination (NCE), administered by the National Board for Certified Counselors, or similar examinations administered by state regulatory boards. Examinations such as the NCE assess basic knowledge and application of core counseling practice concepts. Finally, the experience component ensures that new counselors, both pre - and post-degree, are observed and mentored as they demonstrate expertise and move toward independent practice (Magnuson, Norem, & Wilcoxon, 2002).Taken together, these "three Es" are intended to ensure competency; however, the awarding of licensure or certification signifies only a starting point, reflecting baseline proficiency and initial competency.

Continuing Competency. Continuing professional development beyond this point becomes an internally motivated process, whereby, each counselor must assume the responsibility to pursue genuine and rewarding avenues of professional growth and to engage in activities that will augment counseling proficiency. According to Tobias (2003), while initial professional training is monitored by training programs and regulatory boards, continuing professional education is self-directed. Once credentials such as licensure and certification have been awarded, there are few genuine measures of a counselor's growth, development, and competency in practice. With limited external mechanisms in place to monitor professional development, the responsibility for continuing competency rests upon the shoulders of each counselor. Professional development is considered a cornerstone of ethical practice; however, without external accountability, there are some counselors, the anti-mentors, who do not assume this responsibility.

The Pew Commission Task Force. The Pew Health Professions Commission Taskforce on Healthcare Workforce Regulation was formed, in part, due to apprehension over the type of professional represented by the anti -mentor counselor. The Taskforce was formed in 1989 to investigate issues and concerns related to regulated professions in health care. One of the regulatory concerns investigated was the lack of any true ongoing assessment of the continuing competency of professionals once they have received their licenses. This lack of ongoing assessment has long been identified as a risk to public safety (Citizen Advocacy Center, 2004).

The 1995 Pew Commission Taskforce report contained 10 recommendations for regulatory boards (Finocchio, Dower, McMahon, & Gragnola, and the Taskforce on Health Care Workforce Regulation, 1995). Two of the recommendations specifically addressed continuing competency and emphasized the need to reassess the competency of licensed practitioners post licensure, perhaps through peer review panels or additional testing, in order to assure the safety of the public. Recommendation 3 noted that regulatory practice acts should address not only initial competency, but continuing competency as well. In addition, Recommendation 7 called for state regulatory boards to develop and implement methods to monitor and evaluate the competency of regulated professionals across the span of their careers.

Efforts to Address Continuing Competency . A few regulated health professions have responded in the professional literature with recommendations for the assessment and regulation of continuing competency. A few regulated health professions have responded in the professional literature with recommendations for the assessment and regulation of continuing competency. These include nursing (Ryan-Nicholls, 2003; Whittaker, Carson & Smolenski, 2000), occupational therapy (Moyers, 2004; Woodbury & Velozo, 2005), and respiratory therapy (Tinkler, 2002), but there is no evidence in the literature that mental health professions have made meaningful attempts to assess continuing competency beyond the use of continuing education units (CEU).

The process of continuing education was developed to protect the public (Tobias, 2003), and CEUs have long been established as the primary way to verify sustained professional growth. Although most regulatory boards require evidence of CEUs for licensure renewal, there is no evidence that CEUs assure competency (Finocchio et al., 1995). While CEU workshops and presentations certainly can be instructive and enhancing to compe-

tency, several flaws are inherent within the CEU system.

Just as leading a horse to water does not ensure that the horse will drink; the existence of a CEU certificate does not necessarily indicate that competency was enhanced. In the former case, you need a thirsty horse, and in the latter, counselors with a thirst for learning. Unfortunately, it is possible for a counselor to sign up for a workshop or conference and obtain a CEU certificate without ever setting foot in the venue. Even actual physical presence at a CEU event does not in itself confirm professional development, since the participant may decide to direct his or her attention elsewhere (e.g., attending to a "Blackberry" PDA or napping) during the instructional time. Because it is difficult to gauge whether or not a participant in a CEU activity has actually integrated new knowledge and thereby increased competence, CEUs are inadequate as an assessment of continuing competency (Finocchio et al., 1995).

The increase in distance and correspondence CEU offerings is another concern. While these options are certainly convenient for the counselor, it is questionable whether licensure and credentialing boards can accept the contact hour designations at face value. Hinson and Bradley (n.d.), motivated by regulatory board concerns, found that subjects were able to pass a correspondence CEU test without reading the material. Even subjects who read the material before testing took much less time than the designated CEU time of three contact hours. Regulatory concerns about the veracity of such CEU options appear to be well founded. Continuing education alone does not satisfy the Pew Taskforce's recommendations for genuine appraisal of continuing competency. In fact, the Pew Taskforce believed that the public was not being adequately protected by the use of continuing education documentation as the sole competency measure for licensure renewal (Finocchio et al., 1995). Despite the Pew Taskforce position, there appears to be no substantial post licensure re-assessment requirements for counselors or other mental health professionals at this time (Lundgren & Houseman, 2002).

Scaffolding the Zone of Proximal Development

Counselors who are most noted for their extraordinary strides in professional development appear to be those who are intrinsically motivated toward lifelong learning, apart from the requirements for maintaining their credentials. For such counselors, conferences and workshops represent opportunities to learn and grow and not simply "hoops to jump through" for CEU certificates. If the thirst for knowledge is generated from within, counselor educators and supervisors are in a unique position to foster the development of lifelong learning by embracing continuing competency as a core value and evaluated disposition in counselor training programs. The developmental process of implementing continuing competency can be conceptualized through the work of Vygotsky.

The Vygotsky Model of Learning. We propose that Vygotsky's theory of how one learns can be used as a developmental framework for conceptualizing the scaffolding of continuing competency through mentoring, supervision, consultation, professional involvement, advocacy and self care. In the 1930s, Lev Vygotsky, a Russian psychologist, described a revolutionary theory regarding the relationship between educators and children's learning and development (Henson & Eller, 1999). Vygotsky (1978, 1997a, 1997b) stressed that learning is social and proposed that the educator should be a facilitator rather than simply an orator of knowledge.Vygotsky believed that learning should not be defined simply as one's demonstrable ability, but rather it should be defined as one's potential ability. This ability could be determined only by assessing what the learner was capable of doing if given enough assistance by an educator or peer. Thus, the learner's potential level of development was distinguished from the current, actual ability level. This difference was defined by Vygotsky as the learner's *zone of proximal development*. Vygotsky asserted that the greater the zone of proximal development, the more learning potential the individual possessed. This learning potential may be viewed as knowledge to which one aspires.

Vygotsky's model prescribed that the educator scaffold the learner (Jacobs, 2001). Scaffolding entails providing learners the assistance they need to complete a task, and subsequently withdrawing that assistance gradually until they are able to complete the task on their own. The educator must identify the learner's zone of proximal development, and provide necessary tools until the learner can accomplish the task alone. Thus, the

former zone of proximal development becomes the learner's actual zone of development and the zone of proximal development evolves to a higher level of aspirational knowledge. Stressing the importance of the social/environmental dimension of the learning relationship, Vygotsky (1978, 1997a, 1997b) postulated that the scaffolding process involves the educator interacting with the learner in the zone of proximal development to help the learner attain a higher level of functioning (Jacobs, 2001). This interactive relationship between learner and educator not only increases the learner's knowledge, but also generates awareness of the very process of learning (Vygotsky, 1997a, 1997b).

Scaffolding Strategies

How might Vygotsky's model of learning and development be applied to the counseling profession? Counselors have a zone of actual development or foundational abilities, a current zone of proximal development, and a set professional knowledge and skills to which they aspire. If counselors stay within their demonstrated ability level, they are not being challenged and they may become bored and stagnant. However, placing counselors in situations beyond their current zone of proximal development can lead to frustration and discouragement. Counselors who are scaffolded in their zone of proximal development remain energized as they gain knowledge and proficiency. Scaffolding at the point where the zone of proximal development meets aspiration knowledge is the cutting edge of knowledge and is neither boring nor frustrating. It is an exciting process as new insights occur and new skills are mastered within a supportive yet challenging context. Scaffolding is essentially a co-constructed process that may occur through a variety of collaborative relationships and experiences, and serves to move counselors toward aspirational knowledge.

Mentoring. Mentors empower new professionals and help shape professional identity (Tentoni, 1995). Echterling et al., (2002) described a mentor as "someone who not only teaches you what you want to know but who is the embodiment of who you wish to become" (p. 206). The mentoring relationship is an enriching association not only for the less experienced professional, but also for the mentor. Mentoring is a mechanism for sharing wisdom and is reciprocal in nature (Huang & Lynch, 1999). As the mentor nurtures an apprentice, passing on expertise and wisdom and facilitating development of the apprentice's potential, the mentor revisits his or her own learning discoveries and professional development. Ultimately, the mentor steps aside as the new professional comes into his or her own.

Mentoring can be integrated into the professional lives of counselors, first as the emerging professional is scaffolded within her or his zone of proximal development by an experienced other, and finally as the astute experienced practitioner engages in scaffolding new counselors. Essentially, those who have been mentored will one day provide mentoring for others and the process of scaffolding continuing competency through mentoring will be perpetuated. Incorporating mentoring into a counselor education program and intentionally reaching out to all students would ensure all students access to this scaffolding technique.

Peer supervision and consultation. Supervision is a vital component of both training and licensure and is an excellent example of Vygotsky's concepts. The supervisor scaffolds the less experienced counselor until the novice counselor can demonstrate a desired competency without the assistance of the supervisor. Then, the next desired skill is targeted as a new competency to master and the novice counselor progresses

Bernard and Goodyear (1998) noted that requiring supervision for licensure encourages professionalism, fosters development toward independent practice, and protects clients. Thus, supervision is the ideal representation of continuing competency scaffolding. Supervision should not be seen as merely getting your ticket punched on the way to licensure, but should be viewed as an ongoing aspect of informed practice and continuing competency. In fact, ongoing supervision is an essential part of ethical practice and counselors should seek supervision to assist them in difficult cases or to expand their scope of practice (Corey, Corey, & Callanan, 2003).

Peer supervision has proven to be an effective method for practicing counselors to develop skills and obtain help with difficult cases. Agnew, Vaught, Getz, and Fortune (2000) found that school counselors who participated in peer supervision groups gained a sense of professionalism and increased their consultation and referral skills. Peer supervision groups are an excellent way to continue the supervision process in one's post licensure professional life. A bi-weekly or monthly brown bag lunch supervision group can be readily incorporated into even the busiest counselor's schedule. This is particularly important for sole practitioners who may be isolated and unable to debrief and process on a daily basis with colleagues.

While similar to supervision, consultation does not typically contain an evaluative element (Benshoff & Paisley, 1996). Establishing a peer consultation network or group provides counselors an opportunity for feedback and assistance with difficult cases and general issues. Peer consultation groups have been found to be effective mechanisms for improving counseling practice (Benshoff & Paisley, 1996; Logan, 1997).

Students have formal opportunities for supervision and consultation during practicum and internship, but peer supervision and consultation, as professional virtues, can be emphasized across a counselor education program. Activities such as cooperative projects and consultation case studies stress collaboration with other counselor trainees, thereby normalizing partnership and fostering open communication between professionals. Underscoring peer consultation and supervision within a program as a necessary component of ethical practice will instill these valuable resources as fundamental professional behaviors. Partnership, teamwork, and openness to supervision and consultation can be designated as evaluated dispositions, thereby highlighting the importance of these attributes.

Professional involvement and advocacy. Professional involvement in the American Counseling Association (ACA) and in ACA state divisions provides opportunities for interaction and networking with peers. These networking relationships scaffold the zone of proximal development as they offer occasions for formal and informal exchange of ideas. Professional organizations also offer publications, conferences, and workshops that relate cutting edge developments in the counseling field. Professionally involved counselors are afforded the opportunity to write and present their own ideas, and therefore to contribute to the general knowledge base and overall competency of the profession. Leadership opportunities are usually plentiful at the state level and the self-confidence and experience gained through service to the profession in a leadership position is invaluable.

Professional involvement also gives counselors a sense of distinctiveness and professional selfhood. Daniels (2002) found that membership in professional organizations enhanced a counselor's sense of collective identity. Collective identity, which is the extent to which one identifies with his or her profession, is an important aspect of professionalism and Daniels suggested that training programs intentionally foster trainee involvement in professional organizations.

With encouragement from faculty, collaborative and individual class projects can often be developed into programs that counselor trainees can present at state, regional, and even national conferences. In fact, the authors have encouraged and facilitated students in the submission of class group projects to conferences with much success. These students have gained experience in professionalism and networking which will enhance their development as competent professional counselors.

Another avenue for scaffolding students toward ownership of the profession is through advocacy efforts. Students can be introduced to the concept of advocacy and discuss how counselors might advocate for clients and for the profession. Through this discussion, they can be introduced to modalities of advocacy such as legislative advocacy. After a review of the legislative process, students can be guided to participate in the process. Some steps might include helping them identify their own senators and representatives, encouraging them to become familiar with salient issues, and arranging joint meetings with state or national legislators to discuss issues. This activity could be organized as a field trip for a professional issues class or as an independent activity for post-master's supervisees.

Monitoring personal mental health. Monitoring one's own mental health in order to avoid impairment is a critical hallmark of continuing competency. Counseling is a helping profession, but counselors must balance their caring for others with intentional self-care (Skovholt, 2001). Since self-care is a common goal for many clients, it stands to reason that counselors should model self-care practices that enhance the body, mind and spirit (Schmidt, 2002). Ignoring self-care will certainly lead to stress and may lead to counselor impairment. Because counselor impairment creates a risk to clients, it is our ethical obligation to avoid burnout and seek help for personal problems and issues (Corey et al., 2003). Myers, Mobley and Booth (2003) highlighted the importance of wellness and noted that the "underlying philosophy of counselor preparation rests on a foundation of wellness for professionals and professionals in training" (p. 273). They emphasized wellness as a necessary component of counselor education.

Ongoing self-care, awareness of personal issues, and a willingness to seek professional help are necessary elements of continuing competency, and wellness practices should be emphasized in counseling courses as indispensable components of informed counseling practice. While most counselor educators understand the necessity of addressing student impairment, they may be overlooking stressed students who need to be encouraged in self-care practices. Implementing a wellness self-evaluation by students would highlight the importance of self-care and identify those students in need of intervention.

Academic integration of continuing competency. Taking personal responsibility for continuing competency, and understanding the connection between continuing competency and the ethical responsibility to promote the welfare of clients, can be emphasized at every opportunity in a training program. In each course, the need to be aware of the changes that occur in the counseling field, and the necessity for every counselor to keep up to date on new developments can be underscored by presenting concepts framed within historical progression and societal change. Introducing the zone of proximal development and scaffolding into the program philosophy as a developmental model for the conceptualization of continuing competency would emphasize the ongoing nature of professional growth. In fact, culminating portfolios for graduating students could include a 10, 20, and perhaps even a 30 year plan for the scaffolding of continuing competency. This would underscore the lifelong growth and learning necessary in the counseling profession. Contextualizing lifelong learning in this manner would highlight the need for counselors to establish continuing competency as a lifelong intentional pursuit as they start out on a long, exciting, and purposeful journey toward increasing levels of competency and wisdom as a counselor.

Implications for Counselor Educators and Supervisors

As the primary models of continuing competency, counselor educators and supervisors must own the necessity for the scaffolding of their own practice and professional development. There is never a point where a counselor has learned all there is to know; therefore, it is crucial that counselor educators and supervisors intentionally embrace and model continuing competency. Counselor education programs provide the knowledge base that forms the foundation for continuing competency, but the yearning for aspirational knowledge must be modeled.

Counselor educators and supervisors should be mindful of the behaviors they are exhibiting for supervisees and trainees. When counselor trainees observe faculty members reading professional literature, attending professional conferences, serving as leaders in professional organizations, participating in supervision and consultation groups, integrating new cutting edge knowledge into coursework, and exhibiting wellness practices, the trainees see competency elements in action. By modeling developmental lifelong continuing competency and ethical practice for trainees, counselor educators and supervisors inspire novice counselors to strive for continuing competency which ultimately will enhance the welfare of the public. As counselor educators and supervisors, we must be willing to examine our own professional behaviors through questions such as: How are we scaffolding our own continuing competency? In what ways do we model lifelong learning? How have we incorporated wellness and self-care into our professional lives? Do we exhibit the desire for movement along our zones of proximal development toward aspirational knowledge? Are we exemplars of the value of continuing competency?

Conclusion

It has been over 10 years since the Pew Taskforce made initial recommendations for continuing competency in regulated health professions. Since the recommendations were made, mental health regulatory bodies have discussed the concept, but little has changed in the way post-licensure competency is evaluated. Rather than wait for external regulatory enforcement of continuing competency, counselor educators and supervisors can intentionally promote and model the lifelong pursuit of continuing competency as an ethical responsibility and a core value of exceptional counseling practice. By conceptualizing lifelong learning as a developmental journey, counselor trainees can enter the counseling field energized by a belief in ongoing growth, advancement, and competency as professionals.

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Impact of an Adlerian Based Pretrial Diversion Program: Self Concept and Dissociation

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Abstract

Clients' self concepts and dissociative experiences were examined to determine the impact of an Adlerian based pretrial diversion program. Clients completing the program displayed a significant change in self concepts and dissociative experiences. A repeated measures multivariate analysis of variance indicated a 35% change, made up of the self-concept subscales: Physical, Moral, Social, Academic/Work, and Personal and an overall dissociation score

Introduction

Between 1980 and 2005 the prison population in the United States grew from 500,000 to more than 2 million (Bureau of Justice Statistics, 2006). By 2003, governors and state legislators, faced with a third year of economic crisis sought to reduce costs linked with corrections (Wool & Stemen, 2004). These reductions were especially important in states such as Alabama, where in 2002 the incarceration rate was 43% greater than the national average.

Increased prison populations and economic pressures in the area of corrections signify a need for effective alternatives to incarceration. Restorative justice pretrial diversion programs offer a less costly alternative to incarceration (Latimer, Dowden, & Muise, 2005). However, there is a void in research needed by administrators and community members to determine which programs are most effective (Antonowicz & Ross, 1994; Bonta, Wallace-Capretta, Rooney & McAnoy, 2002; United States Department of Justice, 2003). Items to be addressed by administrators of alternative programs include offender needs such as cognitive skills, substance abuse, living skills, abuse, trauma, employment and education (Hannah-Moffat, 2005; King, 2007; Wood, 2007; Wool & Stemen, 2004). Additionally, alternative programs need clearly defined desired results, measurable indicators to demonstrate success, and activities and resources to monitor the processes in place.

Within the context of restorative justice, offenders atone for their actions via rehabilitation within the community. For example, instead of serving a prison sentence, an offender may be required to pay restitution to the victim and to do volunteer work in the community. Latimer et al. (2005) conducted a meta-analysis surrounding restorative justice practices and found restorative justice programs were significantly more successful at reducing recidivism than non restorative approaches to criminal behavior. However, the voluntary nature of restorative justice programs makes the research problematic. While 20% of participants in the restorative justice program recidivated, 48% of those that refused to participate in restorative justice programs recidivated. These findings indicate that those less likely to recidivate may be more likely to volunteer for such programs.

Research has demonstrated restorative justice is significantly more effective at reducing recidivism in adults than in juveniles (Bonta et al., 2002). Restitution is the factor most associated with reduced recidivism. The incorporation of victim offender meetings provided small decreases in recidivism. Reduced recidivism is associated with a community service element to the program (Harris & Wing Lo, 2002).

Finally, variables such as age, race, employment, geographic area, substance disorders, genetic predictors, physiological predictors, family structure, relationships, or support, dissociative experiences and self concept play a role in recidivism rates (Hannah-Moffat, 2005; Paolucci, Violato, & Schofield, 2000; Snow, Beckman & Brack, 1995).

Marsh and Burnett (2003) acknowledged limited research about the impact of alternative programs on self concept and that within the body of research that does exist weak interventions and designs are present linking program goals and changes in self concept. Hannah-Moffat (2005) reported a link between self concept and recidivism. Decreases in delinquency have also been linked with increases in self concept (Levy, 1997; Craven, Marsh, & Burnett, 2003). Levy found significant differences in self concept of non delinquents as compared with delinquents. Furthermore, Trzesniewski et al. (2006) noted that offenders with improved self concepts experience healthier life outcomes and Craven et al., (2003) reported poor self concept can result in personal and social ineffectiveness. Examples of such personal and social ineffectiveness include violence and criminality. Sweitzer (2005) established a relationship between self concept and social interest in conduct disordered adolescents. Sweitzer found that when these adolescents lacked self concept and social interests they reacted defensively to achieve superiority and protect personal meaning.

Saxe (2001) established connections between dissociation and criminality. Dissociation is "a disruption in the usually integrated functions of the consciousness, memory, identity, or perception of the environment" (p. 243). Individuals with a history of childhood abuse are particularly susceptible to dissociative disorders. Offenders may commit crimes in dissociative states. At least 25% of offenders show pathological levels of dissociation (Moskowitz, 2004). Identification and treatment of such issues is important in the area of offender rehabilitation. Latimer et al. (2005) emphasized the need to be aware of the possible presence of pathological and psychological factors with offenders and the need to provide psychologically informed treatment.

In the current study a within subjects test-retest design was performed post-hoc using archival data. Client files at an Adlerian based restorative pretrial diversion program were examined to answer the following three research questions:

1. Are shifts in both self concepts and dissociative states combining to create a yet undefined multivariate change within clients?
2. Is the program associated with a significant univariate increase in clients' self concepts?
3. Is the program associated with a significant univariate decrease in clients' dissociative experiences?

Method

Participants. Participants were 250 first time nonviolent felony offenders voluntarily participating in the diversion program, in the southeastern United States, between 2002 and 2007. One hundred and fifteen (46%), were African American females, 51 (20%) were African American males, 44 (18%) were Caucasian females, 38 (15%) were Caucasian males, 1 (less than 1%) was a Hispanic female and 1 (less than 1%) was a female who classified herself as other. Seventeen of the participants had a ninth grade education or less, 179 were high school graduates, and 54 had post-high school education.

Instruments. The program in this study tracked changes in clients' self concepts and dissociative experiences. Clients took pretests and posttests including the Tennessee Self Concept Scale: Second Edition (TSCS: 2; Fitts & Warren, 1996) and the Dissociative Experiences Scale (DES; Carlson & Putnam, 1993). The instruments are hand scored. Administrators keep the results of testing on file. Reading levels were assessed using the Wide Range Achievement Test (WRAT3; Wilkinson, 1993). The mean reading level was 44.28 (high school) with a standard deviation of 6.36. The 19 individuals scoring less than 6th grade reading levels on the WRAT3 were provided with a reading coach while taking the TSC: 2 and DES.

Tennessee Self Concept Scale: Second Edition. The TSCS: 2 is a multidimensional self concept assessment instrument for ages 13 and older, takes 10 to 20 minutes to complete, and may be administered individually or in groups (Brown, 1998). The reading level of the adult form of the test is fourth-grade. There are 82 self de-

scriptive statements with 5 response categories for each descriptive statement: always false, mostly false, partly false and partly true, mostly true and always true (Fitts &Warren, 1996). An example of an item from the test is "I can't read very well" (p. 12). The respondent circles 1 for always false, 2 for mostly false, 3 for partly false, 4 for mostly true, and 5 for always true.

Although the second version of the test does not retain all of the original 34 scores from the 1988 version, Fitts and Warren (1996) noted scores in the second version are psychometrically equivalent to those in the first version with a median correlation of .94 between the two versions. Scoring the second version of the test generates 15 separate scores. There are validity scores (Inconsistent Responding, Self-Criticism, Faking Good, and Response Distribution), summary scores (total self concept and conflict), external self concept scales (Physical, Moral, Personal, Family, Social, Academic/Work), and internal supplementary scores (Identity, Satisfaction, and Behavior; Brown, 1998). Self concept relates to the self definition associated with the question, "Who am I?" (Fitts & Warren, 1996). This is different from self esteem. Which relates to the self-evaluation link with the question, "How do I feel about myself?" This study focuses on the 6 external self concept scores. Definitions of each subscale follow.

Physical self concept is the view an individual has about his or her body, state of health, physical appearance, skills, and sexuality. Moral self concept represents feelings of being a good or bad person. Low moral self concept may lead to impulsivity that overrides moral considerations. Personal self concept reflects personal worth and feelings of adequacy as a person. Family self concept indicates feelings of worth and value as a member of a family. Social self concept refers to feelings about adequacy and worth in relation to interactions with others. Academic/Work self concept relates to an individual's perception of self in work and academic settings.

Established norms included 1,944 adults, including United States public high school students, college students, public school staff, members of parent-teacher organizations, members of church, and other community groups (Fitts & Warren, 1996). Fitts and Warren reported internal consistency reliability ranges from .73 on the Social self concept scale to .93 for total self concept. Test-retest reliability ranges from .70 for the Social subscale to .82 for Total self concept.

Fitts and Warren, (1996) reported construct validity using a principal components analysis with varimax rotations. They reported the results of a two-factor extraction and pointed out that the use of positively and negatively worded items calls for separate extractions on each of the subscales for self concept. Their two-factor extraction accounted for 28.7% of the variance. Seven out of seven of the positively worded and 3 out of 7 of the negatively worded items loaded on the Physical subscale. Four out of six of the positively worded and 6 out of 6 of the negatively worded items loaded on the Moral subscale. Six out of six of the positively worded and 5 out of 6 of the negatively worded items loaded on the Personal subscale. Six out of six of the positively worded and 6 out of 6 of the negatively worded items loaded on the Family subscale. Six out of six of the positively worded and 6 out of 6 of the negatively worded items loaded on the Social subscale. Five out of six positively worded and 5 out of 6 of the negatively worded items loaded on the Academic/Work subscale.

Additionally, a principal component analysis using a varimax rotation with separate extractions for positively and negatively worded items accounted for 52.3% of variance in the extraction of the positively worded items and 48.6% of the variance in extraction of the negatively worded items (Fitts & Warren, 1996). In the six factor extraction, six of the seven positively worded and four of the seven negatively worded items loaded on the Physical subscale. Four of the six positively worded and three of the six negatively worded items loaded on the Moral subscale. Three of the six positively worded and four of the six negatively worded items on the Personal subscale loaded. Six of the six positively worded and four of the six negatively worded items loaded on the family subscale. Four of the six positively worded and three of the six negatively worded items loaded on the Social subscale. Four of the six positively worded and five of the six negatively worded items loaded on the Academic/Work subscale. Fitts and Warren reported these results demonstrated reasonably strong support for the Physical, Moral, Family, Social and Academic/Work subscales. They stated that support for the Personal self concept subscale was weak

Dissociative Experiences Scale. DES is a self report inventory that aids in the identification of patients with dissociative psychopathology and serves as a research tool that quantifies dissociative experiences (Juni &

Waller, 1992). Dissociation is "a disruption in the usually integrated functions of the consciousness, memory, identity, or perception of the environment" (Saxe, 2001, p. 243). The DES is appropriate for persons age 18 years and older (Juni & Waller, 1992). Time anticipated for taking the test is 10 minutes. Written at the 10th-grade reading level, it contains 28 items designed around extensive interviews with dissociative patients and specialists in the area of dissociation. An example of an item from the test is, "Some people have the experience of finding new things among their belongings that they do not remember buying" (Carlson & Putnam, 1993, p. 26). The test takers indicate the percentage of time this happens to them.

DES comes in two forms (Juni & Waller, 1992). Each form of the test contains the same items. However, the scale used to rank dissociation linked to each question is slightly different. On the original form, a visual analogue scale requires those taking the test to place a slash on a 100-millimeter line with responses ranking from 0%, "this never happens to you" (p. 7) to 100%, "this always happens to you." The evaluator rounds up or down to the nearest 5 millimeters. DES 2 uses an 11-point Likert scale listing percentages from 0 to 100 in increments of 10 and allows the test taker to circle a percentage indicating the percentage of time the event occurs. Instructions include a statement about drug or alcohol experiences instructing those taking the test to ignore drug or alcohol experiences when responding to the questions. The higher the DES score the more likely a person is to have Dissociative Identity Disorder (Carlson & Putnam, 1993). A score, of higher than 30 on the instrument, indicates Dissociative Identity Disorder. However, in a sample of 1,051 clinical subjects only 17% of those scoring above 30 on the DES had Dissociative Identity Disorder. Archived data in this study consisted of both the DES and the DES: 2 scores.

Test-retest and internal consistency reliabilities for the DES from six studies provide weighted means of .85 and .93 respectively. Factor analysis provided validity for the DES. Limiting factor loadings to .45, no one item loaded on more than one of the three factors associated with the test: amnesia, absorption/imaginative involvement, and depersonalization/de-realization (Juni & Waller, 1992). Zingrone and Alvarado (2002) use a principal components analysis with an oblique rotation and found one factor better accounts for results obtained by the instrument with 50% of the variance accounted for and all items loading on one factor at .32 or higher in a sample size of 308.

Figure 1 DES 2 Likert Scale

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

Procedure. Due to the retrospective nature of the study, no comparable control group was available. Thus, a within subjects test-retest design was performed post-hoc. The researcher used archived data that came from the clients' responses on the Tennessee Self Concept Scale: Second Edition (Fitts & Warren, 1996) and the Dissociative Experiences Scale (Carlson & Putnam, 1993). The statistical analysis used was a doubly multivariate analysis of variance (MANOVA; Grim & Yarnold, 1995). The MANOVA is effective when the same respondents provide several measures over time and the researcher wishes to examine the data to see if any trends materialize (Hair, Black, Babin, Anderson & Tatham, 2006). Using the repeated measure MANOVA researchers can account for the dependence present in such a test-retest design while at the same time researchers can determine whether differences, beyond those expected by chance alone, occurred across individuals for a set of dependent variables.

The researcher received approval for the research from the Institutional Review Board at Amridge University. A review of the archived clients' files took place. Files containing the genders and races of clients, answers to both pretest and posttest for the Tennessee Self Concept Scale: Second Edition (TSCS: 2; Fitts & Warren, 1996) and the Dissociative Experiences Scale (DES; Carlson & Putnam, 1993) were included in the study. Code numbers were assigned to clients' files and used to differentiate clients in the data file. Client responses to the items in the TSCS: 2 and the DES were entered into the statistical software package: SPSS. The researcher used SPSS to perform a repeated measure multivariate analysis of variance (MANOVA) on the data.

Intervention. The pretrial diversion program in this study is an Adlerian based, restorative justice program

based on the idea that crime is a violation of people and relationships (Guest, 1991). First time, nonviolent, felony offenders may apply. An applicant must write a letter of apology to the victims and appear before a commission, made up of members of the community appointed by the presiding criminal judge. Members of the committee meet jointly with each individual applicant, an applicant's family member or friend, and the applicant's attorney to question the applicant about his or her crime and allow the friend or family member and the applicant's attorney to speak on the applicant's behalf. Victims must grant written consent for offenders to participate and may also attend the meeting and make comments. In order for the applicant to become a client in the program, a majority vote is needed from the committee.

Mock commissions are held the evening before the commission meetings. Clients, currently in the program, earn community service hours for attending the mock commission meetings and acting as commissioners. They are role models in this process confronting applicants applying to the program in constructive ways. This allows applicants to get feedback from their peers related to the crime they committed, the demands of the program, and the benefits of the program.

Counselors working in the program use an Adlerian based group counseling process that revolves around the concept of social interest (Guest, 2001). The ultimate goal of the counseling aspect of the program is to help clients experience cognitive shifts in thinking that take them away from the criminal subcultures and thinking and instead inspire them to invest in social interest linked to conventional society. Elements of the program connect each of the five life tasks associated with Adlerian theory: work, friendship, love/intimacy, self-acceptance, and spirituality (Adler, 1991; Dreikurs & Moska, 1967; Mosak & Dreikurs, 2000; Sweeney, 1998). Individuals' feelings about themselves and levels of self-acceptance determine how they are able to form interpersonal relationships and ultimately how successful they are at achieving social interest. In relation to the life task of work, clients are required to complete 300 hours of community service, consistently have a job, and do continuing education. Intake officers monitor clients to ensure they are meeting these requirements. Additionally, clients pay complete restitution to victims and take random drug screens. The counseling portion of the program covers the last four life tasks. Friendship involves relating to others and establishing healthy relationships. Love/intimacy relates to achieving bonds of familiarity, closeness, love and intimacy with a group. Self-acceptance relates to learning to like and appreciate self. Spirituality centers on clients' values, life meanings, and goals. Clients attend a minimum of eight individual counseling sessions where they build a genogram with a counselor and begin to understand the private logic that is driving current faulty life goals. In conjunction with individual counseling, they also spend at least a year in a four phase semi-structured group counseling program. A new healthy support network in the form of the staff, counselors and group members replaces the unhealthy relationships. Group is a social framework where clients can develop a healthy sense of belonging and community (Carlson, Maniacci & Watts, 2006). Within the program the goal of the group therapy is to "help clients live a socially useful lifestyle" (Guest, 2001, p. ix). Positive self concept and identity is the basis of such a lifestyle. However, the key to change is ensuring clients' positive self concepts and identities have no connection with criminal subcultures or faulty thinking.

The group counseling process has four phases: *I am Conflicted*, *I am Mad*; *I came from a Family;* and *I am Becoming* (Guest, 2001). In the conflicted stage, the focus is on understanding of the personal integrity and belief systems at the core of the clients' value systems. Clients explore individual thoughts and feelings and how these thoughts and feelings influence behavior. The mad stage breaks down denial of anger with the goal of reducing anger situations and learning effective coping skills. During the family stage, clients analyze family systems using their genograms and sculpting their family of origins in an effort to confront denial and gain an understanding of the life goals driving behavior. During the becoming stage, clients recognize and accept childhood needs still present due to abuse, neglect, or pampering and emotional healing occurs. Throughout the process group counselors question mistaken thinking, identify, and help change the life goals that drove clients when they committed their crimes.

Structured exercises and scripts (Guest, 2001) guide the group process. The final exercise in group requires clients to write a fairytale. Disque and Bitter (1998) noted that our lives take the form of a story or narratives "about who we are; who others are; what we are worth to ourselves, others and the world and what conclusions, convictions, and ethical codes will guide us" (p. 431). In the final stage, clients "use their imagination to develop a new life script which does not include victimization and which integrates ego states in a healthy

way" (Guest, 2001, p. 129). The stories illustrate the breaking of unhealthy patterns and allow healing by way of the rewriting of life scripts.

Finally, visualizations are a part of each phase of the group process. Visualizations help in generating and working through conjunctive feelings (Dinkmeyer, Kottman & Ling 1991). For example, in the final phase of the group work, the visualizations center on abuse issues. In one of the visualization, the clients confront childhood abusers and return the negative feelings the clients still carry regarding the abuse.

Results

Main Hypotheses and Analyses. Hypothesis 1: There are significant multivariate differences between the pretest and posttest scores of self concept as measured by the external subscales of the TSCS: 2 and dissociative experiences as measured by the DES. In the multivariate analysis of the data, Pillai's criterion = .35 and the within subjects multivariate $F = 18.76$, $p = .00$, $\eta^2 = .35$, with the observed power (.05 level) equaling .99. This indicates that changes in self concept and dissociation combined together to create a significant change in clients completing the program. Hypothesis 2: There are significant univariate differences between the pretest and posttest scores of self concept as measured by the external subscales of the TSCS: 2 and hypothesis 3: There are significant univariate differences between the pretest and posttest scores of dissociation as measured by DES. Univariate analysis of the six subscales on the TSCS: 2 and of the DES scores revealed significant pretest-posttest differences on the Physical, Moral, Personal, Social, Academic/Work subscales ($p = .00$ on all 5) and dissociation ($p = .00$). However, the family subscale revealed no significant change. Tables 1 and 2 show the results of the multivariate and univariate analysis.

The multivariate effect size in this study is .35. The univariate effect sizes are: Physical .09, Moral .18, Personal .18, Social .08, Academic/Work .17 and Dissociation .09. What this means is that the program, as implemented in the sample, explains 35% of the differences in the linear combination of the set of treatment indicators (i.e. Physical, Moral, Personal, Social and Academic/Work subscales of self concept and Dissociation). Examination of each indicator individually indicated Physical self concept accounted for 9% of the difference, Moral self concept accounted for 18% of the difference, Personal self concept accounted for 18% of the difference, Social self concept accounted for 8% of the difference, and Academic/Work self concept accounted for 17% of the difference.

Table 1

Multivariate Analysis Variance

Model	Pillai's criterion	*F* ratio	DF	*p*	η^2	OP
Within Subjects	.35	18.75	7	.00	.35	.99

Note. DF=degrees of freedom; *p*=significance level; η^2= partial eta squared; OP=observed power

Table 2

Univariate Analysis of Within-Subjects Variance

Source Variance	SS	*F* ratio	DF	*p*	η^2	OP
Effect Physical	1051.25	24.64	1	.00	.09	.99
Error Physical	10622.25		249			
Effect Moral	1627.21	53.52	1	.00	.18	.99
Error Moral	7570.79		249			
Effect Personal	1797.41	56.31	1	.00	.18	.99
Error Personal	7947.59		249			
Effect Family	1.06	.03	1	.86	.00	.05
Error Family	8676.44		249			
Effect Social	453.15	22.66	1	.00	.08	.99
Error Social	4978.85		249			
Effect Acad/Work	1028.18	52.05	1	.00	.17	.99
Error Acad/Work	13070.98		249			
Effect Dissociation	836.20	20.76	1	.00	.08	.99
Error Dissociation	10040.04		249			

Note. SS=sum of squares; DF=degrees of freedom; *p*=significance level; η^2=partial eta squared; OP=observed power

Table 3 contains a summary of the pretest and posttest results for the means of the dependent variables and presents the standard deviations, the standard errors, and the lower bound and upper bound of a 95% confidence interval. On the TSCS: 2 higher scores indicate greater self concept. An increase in the means of the all subscales except family is present. This indicates an increase in clients' self concepts after participation in the program in all areas except family. On the DES higher scores represent more dissociation. A decrease in the mean of the DES scores indicates a decrease in clients' dissociations after completing the program.

Table 3

Pretest-Posttest Means, Standard Deviations, Standard Errors, N, and Confidence Levels

				95% Confidence interval		
Measure	**Mean**	**SD**	**SE**	**Lower**	**Upper**	**N**
Pretest Physical	53.32	9.20	.58	52.17	54.47	250
Posttest Physical	56.22	7.17	.45	55.33	57.11	250
Pretest Moral	44.82	6.67	.42	43.99	45.66	250
Posttest Moral	48.43	5.98	.38	47.69	49.18	250
Pretest Personal	45.37	6.56	.42	44.56	46.19	250
Posttest Personal	49.16	5.24	.33	48.51	49.82	250
Pretest Family	45.18	7.24	.46	44.28	46.08	250
Posttest Family	45.09	6.61	.42	44.26	45.91	250
Pretest Social	47.40	5.72	.362	46.69	48.12	250
Posttest Social	49.31	4.84	.306	48.70	49.91	250
Pretest Acad/Work	45.20	6.36	.402	44.41	45.30	250
Posttest Acad/Work	48.07	5.64	.36	47.37	48.77	250
Pretest DES	10.39	3.50	.56	9.28	11.49	250
Posttest DES	7.80	2.78	.45	6.92	8.68	250

Note. SD=standard deviation; SE=standard error; N=number in sample

This is the first study to review the impact of an Adlerian based counseling program in a restorative justice setting on clients' self concepts and dissociative experiences. Strengths of the study include: clearly defined program goals linked to self concept and dissociative experiences, the use of instruments with established validity and reliability and built in faking good measures, detailed information on processes used to help consumers understand why and how results occurred, and program integrity (i.e. program consistently implemented the same way for all clients). The results indicate a significant increase in self concept and decrease in dissociative experiences occur in this program and that these changes combined to create an undefined 35% significant change in clients participating in the program. In light of the program's low recidivism rate, (4% of clients completing the program reoffend), these findings support research establishing a link between recidivism and self concept and dissociative experiences (Craven, et al. 2003; Hannah-Moffat, 2005; Levey, 1997; Trzeniewski et al., 2006; Saxe, 2001; Sweitzer, 2005). However, additional research is needed to determine if clients that recidivate experience similar shifts in self concept and dissociation.

Clients did not experience a significant change in relation to the family subscale of self concept. This may in part be linked to the program design. A large part of the third phase of the group process encourages clients to view faulty thinking patterns and begin to change the poor choices that have often come down from one generation to the next in families. Because family counseling is not included in the program family members do not have the same opportunities to grow and change and may display resistance as clients begin to change faulty thinking. This may be an area that the program needs to explore. For example, couples counseling could help spouses who did not offend adjust to the changes taking place as spouses that did offend progress through the program. Options akin to support groups for family members to help them better understand the demands of the program and give them a forum to voice the frustrations that come along with those demands could also prove helpful. Another consideration in this area is that the program uses Adlerian based, restorative justice concepts to guide offenders away from criminal subcultures and increase offenders' social interests in conventional society. Sometimes the criminal subculture can be present within the family. This may also explain why a significant change in the family subscale of self concept was not present. Further research in this area is essential because there is a link between the Moral subscale and the Family subscale. Fitts and Warren (1996) reported that low Family subscales are often associated with low Moral subscales for individuals with conduct related difficulties.

Methodological limitations in this study include random assignment issues, volunteer bias, the self-report nature of the instruments used, and demographic issues (i.e. geographical location and race) and finally other variables (i.e. familial, etc.) that were outside the control of the researcher. Random assignment did not occur and volunteer bias may limit generalization of the results. The nature of programs like the one in this study is that the process is voluntary. Offenders can discontinue the program at any point. Self selection impacts research because clients that will not recidivate may self-select into the program while those that will recidivate may elect not to participate in the program. The self-reported nature of the instruments used is another bias. Offenders may have answered instruments based on their perceptions of raters or peers expectations. However, the Tennessee Self Concept Scale: Second Edition (Fitts & Warren, 1996) has a scale built in to detect clients faking good and instruments indicating clients were faking good were not included in this study. The study took place in the southeast United States and the sample consisted primarily of African Americans and Caucasians. This limits the results. Finally, other factors outside of the researchers control such as family relationships may influence results.

As community leaders continue to struggle with increasing numbers of incarnated individuals and decreasing funding for corrections, Adlerian based restorative justice pretrial diversion programs hold promise as an effective alternative to incarceration for first time nonviolent felony offenders. By aiding clients in shifting faulty thinking and life goals that drove criminal behavior the program in this study increased clients self concepts and decrease dissociative experiences. This program goes beyond the punitive element of corrections and aids clients in determining who they are, how to stay present moment to moment and how apply healthy thinking and life goals to achieve desired outcomes in their lives so that they do not recidivate.

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Students' Perception on the Effect of Participating in a Study Abroad Program On One's Multicultural and Professional Identity

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Abstract

Research shows that participating in various types of study abroad experiences may have an impact on student learning and awareness. Structured travel experiences that expose students to diverse cultures emphasize using international travel tend to produce individual awareness, change, and growth. This article explores two student's perceptions on the effect of participating in a study abroad program on their multicultural and professional identity.

Introduction

Short-term study abroad experiences are the most common type of study abroad programs in the United States. According to the Institute of International Education's 2008 Open Doors report, more than half of all American students who studied abroad in the 2006-07 academic year (55.4 percent) participated in short-term programs (Donnelly-Smith, 2009). Short-term programs can range from weeklong programs in conjunction with a single course, to three- or four-week programs conducted during terms or in the summer, to longer programs of up to eight weeks that can involve homestays, travel to multiple sites, and service or research experiences (Donnelly-Smith).

Background

In May of 2009, the University of Alabama at Birmingham's (UAB) Counselor Education Program, in conjunction with Old Dominion University's Counseling and Human Services Department offered a two-week study abroad program in Italy. Participating counselor education students were enrolled in three hours of elective credit entitled, "A Counselor's View of Italy." The goal of this course was to provide students with an understanding of the role culture plays in counseling, with a specific focus on the counseling profession within Italy. Faculty members of this program agreed students would get the most out of this type of program if it was highly structured, require ongoing reflection, and included in-depth experience working or studying with host country participants.

The following learning objectives were developed to address the goal of the course:

1. To develop an understanding of the culture and people of Italy that have had an impact on the development of the counseling profession;
2. To develop an awareness of the state of development of the counseling profession in Italy in comparison with the development of the counseling profession in the United States;
3. To interact with Italian counselors and other mental health professionals to understand how counseling is provided to Italian clients;
4. To learn about social and political issues in Italy that are having an impact on the development of the counseling profession;
5. To learn about professionalization activities in Italy including the establishment of a national certification board, efforts to get counseling recognized by the Italian government, and the creation of jobs for counselors in Italy (Author, 2010).

During the two-week institute, participating students attended 30 hours of classroom instruction related to counseling in Italy, and special topics in counseling including areas such as legal issues in counseling, play therapy, cinema-therapy, social justice, and diversity issues in counseling. After each lesson, students were required to write a reaction to the content, relating the content to one or more multicultural principles as discussed in the course text.

According to Donnelly-Smith (2009), students have fewer authentic experiences when they spend much of their time travelling around. Spending the entire program in one locale can allow students to interact more authentically with host country residents, whether in the classroom, in service programs, or in short-term homestays. Donnelly-Smith also believes universities and colleges should also strive to offer all or at least most of their short-term programs internally, rather than relying on external service providers, many of which offer academically weak programs that are more focused on tourism.

Participants in this program spent the majority of their time in Reggello, Italy at a retreat center named *Casa Cares.* At *Casa Cares*, students ate, slept, and attended most of the 30 hours of instruction. Students also traveled to Florence to visit with mental health professionals at a mental health center and a "half-way" house. During these interactions, students attended a session with art and play therapists. Additionally while in Florence, students met with juvenile judicial authorities to learn about how mental health services were provided to juveniles who were involved in the court system. All other seminars led by Italian mental health professionals (psychiatrists, psychologists, social workers, and public educators) were held at *Casa Cares*.

Two areas of discovery were continually presented to participating students: (a) one's multicultural identity and (b) professional identity:

Multicultural Identity. Cultural awareness, sensitivity, knowledge and skills are necessary ingredients for counselor multicultural competence (Burnett, Hamel, Long, 2004). Furthermore, immersion into a diverse community can often help counseling students move beyond their acquired knowledge and help impact their multicultural identity. Additionally and as important, a lack of understanding of self in relation to others is a critical error that beginning counselors often make. Therefore, understanding the socio-cultural aspects of diverse communities is an important step on the road to counseling students acquiring multicultural competency (Burnett, Hamel, Long, 2004).

By creating an opportunity for immersion into the Italian culture, students from UAB were provided opportunities to gain multicultural counseling awareness, knowledge and skills with individuals from another culture. Throughout the two-week experience, students were provided opportunities to discuss their cultural beliefs and experiences with students from other universities. They also were provided numerous opportunities to confront and explore situations and dilemmas from culturally different perspectives. These experiences were accomplished through presentations by Italian and American counseling professionals, reading literature and listening to lectures on cultural identity and multicultural counseling theories and techniques. Pope-Davis, Breaux, & Liu (1997) support these activities believing that ongoing participation in group activities with individuals of other cultures allows students to become actively involved as participants in their own learning. As a result, students are able to enhance their learning and training by directly experiencing how diverse groups define and experience themselves. Burnett, Hamel, and Long (2004) believed the depth of a cultural exposure can transforms students' perceptions of others as well as in self-relation to others. This concept most directly identified the opportunity students had to examine and articulate their multicultural identity and awareness. Supporting this Kottler (1997), believed exposure to international populations through travel provides transformative learning experiences that influence and help change the lives of the participants.

Professional Identity. According to Gale and Austin (2003), the lack of a specific identity for professional counselors has may causes: counselors often receive training from different certifying, licensing, and accrediting bodies; counselors often belong to multiple professional organizations that may hold opposing views; counselors often acquire multiple certificates/credentials/licenses and believe they "owe" particular groups their allegiance; and counselors may be required to adhere to different and sometimes conflicting codes of ethics.

Weinrach (1987) found counseling's lack of identity understandable, proposing counseling's identity has always been confusing, even to those who have worked in the field for decades. Weinrach suggested counseling falls somewhere between education and psychology, citing that in counseling literature, theories and role models come from these two disciplines.

An important goal for new counselors to attain is not only to develop a strong professional identity, but to also be able to articulate what that identity looks like and how it manifests itself in one's professional life (Smith, 2001, Remley & Herlihy, 2010). Attaining a professional identity is a process not an end upon itself. Remley and Herlihy, further expanded on the acquisition of professional identity by stating, "developing a professional identity as a counselor includes understanding the history and development of counseling and related professions, knowing the professional roles and functions of counselors and how these are similar to and different from other professions, learning about and becoming involved in professional organizations, gaining awareness of counselor preparation standards and credentialing, and knowing how to advocate for your clients and your profession." (p. 3).

Examining one's professional identity also requires reflective effort through study and critical engagement with others. Questioning and examining the answers to these questions seem to be paramount to obtaining a professional identity. Remley and Herlihy (2010), postulated the following questions for novice counseling students:

1. Are you able to explain who you are as a member of a professional group?
2. Are you able to articulate what you believe? and
3. Are you able to explain how you are similar and different from other fro other health professionals?

Students who attended this study away program examined these questions along with areas pertaining to multicultural identity for two weeks while examining the counseling profession in Italy. Two UAB Counselor Education master's level students who attended the described study away program present the following narratives. Each student shares her view of the impact of participating in this program on her multicultural awareness and professional identity.

Insights Into My Multicultural and Professional Identity Derived from

Participating in "A Counselor's View of Italy"

Lynn English

Multicultural Identity. Acclimating one's self to another world can be difficult, but also enlightening. As a result of spending two weeks in a foreign land, I felt I developed a greater empathy for those who, in America, are unfamiliar with our customs and our primary language. I noticed in restaurants, the menus were printed in Italian, with English translations beneath. This caused me to question how many restaurants here translate their menus for their non-English speaking patrons? I also observed in Italian conversations, most people seem to speak at once, whereas here, we try to speak one at a time. One culture's polite is another culture's rude? Culture is one aspect of an individual's personal identity, and when we, as a society, diminish a culture, we demean all individuals who identify with that culture. Italy has lost none of her charm, nor appeal, by being respectful of parts of culture that differ from the national norm; couldn't we, in the U.S., take it a step further, and not only show tolerance, but embrace whole-heartedly, all cultures different from us?

Since coming home, I have been more aware of "hidden people," those people whom our society deems insignificant or unimportant. Some of these groups have advocates, many do not. Our culture makes an effort to promote certain groups, but too many others remain hidden. Advocacy for all is what I see as the true meaning of multicultural awareness in counseling.

Professional Identity. Up until the time we left in May, my professional identity was "graduate student in counselor education." I saw myself as a *future* counselor, but I was still not ready to see myself "in the big chair." I wasn't sure exactly what this adventure was going to bring, but I felt I was ready to go wherever it

led me. What I gained from this adventure was a further development of my professional identity as defined through classes and networking.

Every other day, we participated in classes: both outside and inside of our villa and some in the city of Firenze (Florence). Many of these classes addressed counseling in Italy, but there were some that addressed professional issues in counseling here in the U.S. Seminars examining Counselor Wellness, Play Therapy, Spirituality and Religion in Counseling, and Cinema-therapy all opened doors and windows for me. These are not topics taught in our graduate classes, and although we have touched on some of these topics in professional development seminars, during our time in Italy they were presented in a more thorough manner.I was also exposed to students and professors from other universities. We discussed our respective programs, the similarities (primarily due to accreditation by the Council for Accreditation of Counseling and Related Educational Programs), and the differences between programs (difference between how courses are presented and taught; and how some programs require students to complete the practicum portion of clinical training before taking their comprehensive exam, while others require students to pass their comprehensive exam before any clinical training can be taken). We also discussed our own, and each other's, future professional plans after graduation. The professors were also intriguing, and interesting to engage in conversation outside of the classroom experience. It was a great experience to see them in a relaxed atmosphere and to hear their perspectives on our profession, which to me made them all the more admirable and approachable. These other students and professors are future professional peers, resources and contacts with whom I can communicate.

BrieAnna Gesinski

Multicultural Identity. My overall intentions for this study abroad experience focused on my interest in learning about Italians' cultural viewpoint of counseling. Specifically, I wanted to learn how religion accompanied the peoples' support systems to cope with everyday life and stressors. Upon my arrival and quick integration into the Italian lifestyle, I formed some beliefs and assumptions based upon my observations. I believe Roman Catholicism plays a large role in the formation and support of one's identity within the Italian culture. Roman Catholicism is a pillar of strength in which a large majority of the culture looks to for guidance, advice and support in all aspects of living. With this, I believe counseling in Italy is in the beginning stages of development due to peoples' misunderstanding of theintended purpose of professional counselors. At the present time, many individuals rely upon their priests to play the role of counselor. They turn to their faith for support in times of need and look to their priests as the sole support system outside of their families. This may be well intended; however, I believe there may be times when a priest may provide a religiously biased view of a decision with which an individual is struggling. In order for clients to make the best decision for themselves, they need to feel supported and understood by their counselor without being judged. Because of the different moral and political issues that often arise with a client, counselors need to be aware of their biases and prepared to leave their personal beliefs out of their clients' counseling sessions. As the counseling profession continues to grow and develop in Italy, I believe professional organizations must work together to establish boundaries and standards for counselors in Italy. Religion can be used as a tool for guidance and support in a client's choices as long as the client feels comfortable and congruent with this decision and not forced to do so because of his or her counselor's personal viewpoint.

Professional Identity. While in Italy, I had the opportunity to reflect and grow personally as well as a professional school counselor. I gained perspective into what makes my own life "whole" and how to work towards complete integration of my counseling style into all aspects of my life. Authenticity is an important aspect of developing a trusting relationship with one's clients. Being congruent as a counselor in my personal and professional life will help to lay the groundwork for being an effective school counselor.

My Italian experience helped me recognize that when at home, I allow myself to be caught up in the "rat race" of success. I often forget to slow down and listen to my own body and take care of myself both physically and emotionally. This has not only de-sensitized me to my own emotions and reactions to others, but has quickly begun to erode my personal well-being.

I realized how important it is to set aside time each week for personal rejuvenation and self-reflection. For me, nature and quiet time provide reflection and self-growth for my often weary and worn out body and mind. In order to be a fully effective counselor, I must be in tune to my own needs and be willing to take time to take care of myself. To extend myself fully in assisting my students, I must be open to examining my personal life, responsibilities, decisions and emotions. As a school counselor, I will need to be alert and prepared to advocate for children in circumstances they may have little or no control over. In order to do this with a clear and conscious mind, I must take care of my personal expectations and emotions and recognize when they may be interfering with a decision regarding my students. The development of my professional identity must be a continuous and ever-evolving process. As I grow into the counseling profession, times and standards will change. With these changes comes the responsibility that is both ethical and professional; I, too, must continue to examine my belief system, learn about new counseling ideas and adapt to the changes within the counseling profession.

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Psychological Treatments to Avoid

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Abstract

Certain psychological treatments should be avoided, and a list of such treatments would provide valuable guidance for counselors, as well as potential clients. It is well established that some therapies are potentially dangerous, and some fringe therapies are highly unlikely to help clients beyond a placebo effect. This article provides an overview of the need for lists of such treatments, cautions about such lists, and examples of lists of therapies that should be avoided because they are unsafe and/or highly unlikely to be effective.

Psychological Treatments to Avoid

One issue of interest to counselors and psychotherapists today is the proliferation of new, unproven therapies and a lack of regulation or guidance from professional bodies. Not all psychotherapies are equally safe and effective, and a list of treatments to avoid would help both psychotherapists and clients avoid possibly harmful therapies. It is relatively simple and easy for any counselor, social worker, or psychologist to create a new form of psychotherapy, practice it, and offer training workshops on it, even if there is little or no evidence of its safety or effectiveness. Creativity and innovation should be encouraged, but the creators of new therapies should be expected to conduct enough research to demonstrate the safety and effectiveness of the new approach. Prospective counseling and psychotherapy clients must often find themselves confused regarding how to select a practitioner or a therapy given the diverse array of types of counseling and psychotherapy available. The field of counseling should directly address the potential for harm, as well as benefit, that may result from counseling (Dimidjian & Hollon, 2010). It is in the best interest of both counselors and prospective clients to give a preference to well-supported therapies and avoid poorly supported and/or potentially dangerous therapies.

In recent years much effort has been expended to identify counseling and psychotherapy treatments and techniques that have empirical support for their efficacy. Lists of empirically supported treatments (ESTs) have been compiled and disseminated (e.g., Chambless & Ollendick, 2001). Of course there are many therapies that may be just as effective as the ESTs but which do not yet have sufficient research backing to be put on the lists of ESTs (Levant & Hasan, 2008). Despite the lists, counselors and psychologists are not required to use ESTs or evidence-based treatments, and some therapists question the assumption that psychological problems can be objectified and resolved by packaged treatments (Hunsberger, 2007). While listing ESTs is a worthwhile endeavor, they do not help therapists or clients who are trying to distinguish among all of the therapies *not* on the lists. In addition to lists of ESTs, it would also be helpful to have a list of therapies that are, at least for now, best avoided due to their lack of research support and/or their demonstrated or potential harmful effects.

Thought Field Therapy: A Popular, Poorly Supported Therapy

Thought Field Therapy (TFT) is an example of a therapy that has minimal support and yet has numerous practitioners and a thriving training business. TFT is so "outlandish" (Corsini, 2001, p. 689) that it appears to be "a hoax, concocted by some clever prankster to spoof 'fringe' therapies" (McNally, 2001, p. 1171). In a typical protocol to treat a phobia, clients are asked to tap various spots on their bodies in a specific sequence while humming a tune and thinking of the feared object (APA Monitor, 1999a). The inventor of TFT claims it works in five minutes, "eliminates most negative emotions," and has "high success with any problem at any age" (Callahan, 1998, p. 71); he claims it works not only with humans but also with horses, dogs, and cats (Callahan, 2001). Even Callahan himself admits that TFT "certainly looks ridiculous" (Boodman, 2004, p. HE01).

Guadiano and Herbert (2000) reviewed the few studies on TFT and concluded that there is no evidence it does what it claims to do. McNally (2001) evaluated Callahan's assertions and concluded that TFT "lacks any credible theory or convincing data" (p. 1173). Herbert (quoted in Boodman, 2004) concluded that despite the claims, there is absolutely no scientific evidence for TFT. Nevertheless, Callahan has trained thousands of therapists, at least 17 of whom practice Callahan's Voice Technology method, which costs $100,000 for a three-day training workshop (Callahan, 2009). One TFT practitioner (Patton, 2005) advertised a 90% success rate using TFT to treat almost all psychological problems by telephone, and charged $2,500 for a five-hour treatment package. Callahan and other TFT practitioners have established successful commercial businesses, but there is no way for a prospective client to know whether the method is safe or effective. For most therapists, Callahan's anecdotes and small, uncontrolled studies simply do not provide convincing support for his therapeutic approach. Only controlled research could establish whether TFT has any effect beyond a placebo effect.

Thought Field Therapy has received much negative attention. First, the Federal Trade Commission (FTC) forced Roger Callahan, the creator of TFT, to stop making unsupported claims about the therapy, and fined him $50,000 (Federal Trade Commission, 1998). Then the Arizona Board of Psychologist Examiners placed a psychologist on probation for practicing Thought Field Therapy (APA Monitor, 1999a). Finally, the Continuing Professional Education Committee of the American Psychological Association decided to no longer approve continuing education training in TFT (APA Monitor, 1999b). This provides a very rare example of a professional organization making a decision to withdraw support for a specific approach. Judging from the many advertisements for TFT and its imitators in current professional magazines and newsletters, these actions have done little to restrain the proliferation of TFT and other "energy therapies," and books and workshops teaching therapists how to supposedly manipulate invisible energy fields to resolve psychological disturbances continue to be published.

The Need to Identify Unsupported Treatments

One controversial psychotherapeutic technique has actually been outlawed in one state; rebirthing is prohibited in Colorado (Mercer, Sarner, Rosa, & Costa, 2003). Some psychologists have lost their licenses due to their practice of unusual and poorly supported therapies, and others have come close to being sent to prison (Thomason, 2005). An interesting historical example of a psychotherapy that it is illegal to practice is Wilhelm Reich's orgone box therapy, which was prohibited by federal health regulations (Cummings & Cummings, 2008).

Legislation has been proposed that would limit the use of some techniques by psychotherapists; "Fifteen state legislatures have enacted laws to protect consumers from experimental mental health practices" (Singer & Nievod, 2004, p. 177). Such efforts are often unsuccessful. For example, in Arizona in 1999 a piece of legislation called the Barden bill was proposed which would have required each therapist to present two refereed journal articles to each client before implementing each intervention in the psychotherapy process. Barden said "It is indeed shocking that many, if not most forms of psychotherapy currently offered to consumers are not supported by credible scientific evidence" (Barden, 1999, p.2). The bill would "limit psychotherapy to only those methods and techniques that have been scientifically substantiated by a minimum of two research studies that contain control groups" (Barden, 1999, p. 3). In her veto of the Barden bill, the Arizona governor said "there are no other illnesses for which a state sponsored committee outlines plans of acceptable medications, therapy or treatment" (Hofmann, 2000, p. 3). Arizona psychologists had fought the bill since it would have limited their choice of therapies, but the experience suggested that counselors and psychotherapists must consider the safety and effectiveness of psychotherapies and should avoid therapies far outside the mainstream of standard practice.

Lilienfeld (2007) suggested that until recently psychologists have paid little attention to identifying potentially harmful therapies, and this could result in harm to clients. His view is that it is actually more important to identify therapies that are potentially dangerous than to identify empirically supported therapies. It is probably easier to identify therapies that should be avoided than therapies that are safe and effective.

The professions of counseling and psychology have not always done a good job of policing themselves, and as a result people who participate in certain therapies have been harmed in various ways. According to Fox (1996), "Our discipline lacks effective measures for responding to irresponsible and outrageous public claims made by either clinicians or scientists (p. 780). The ethical principles of the American Psychological Association (2002) requires psychologists to avoid harming their clients, but the APA has not compiled a list of therapies that are potentially or actually harmful. One could infer that psychologists can practice any therapy they like, as long as they do not hurt their clients.

The Code of Ethics of the American Counseling Association (2005) states that counselors use procedures that are grounded in theory and/or have an empirical or scientific foundation, and that they should use practices based on rigorous research. The Rebirthing therapists who smothered Candace Newmaker did not intend to kill her, but their technique was inherently dangerous (Mercer, Sarner, Rosa, & Costa, 2002), and it was not based on rigorous research. Are there other therapies that are clearly so bizarre, unsupported, or dangerous that no one should practice them? Such a list would name therapies that are best avoided until research is available that demonstrates their safety and effectiveness. Such a list would also demonstrate to the public that psychotherapists value public safety more than the freedom to practice any approach that has been created.

It is well established that some clients are harmed by participating in certain types of counseling and psychotherapy (Mohr, 1995; Boisvert & Faust, 2003). Several prominent psychologists have described the dangers inherent in the practice of unvalidated treatments. Ronald E. Fox, a former president of the American Psychological Association, wrote that "a few charlatans (or quacks, to put it bluntly) are giving both our profession and our science a black eye" (Fox, 1996, p. 778); "new therapies are invented at the drop of a hat" and "unproved and unfounded theories are advanced as if they were legitimate" (p. 780). Cummings, another former president of the American Psychological Association, wrote that "We have too many charlatans and kooks" in psychology; "We know they are there, and we allow them to practice and potentially harm clients" (Cummings & O'Donohue, 2008, p. 184); "We need to get our house in order and enforce reasonable quality and evidential standards for the practice of psychology" (Cummings & O'Donohue, p. 184), and the APA should denounce "these deleterious interventions" (p. 304). Psychologists should define quality standards, note them in our ethical code, and "Infractions should be detected and adjudicated" (Cummings & O'Donohue, p. 185). Gaudiano (2003) wrote that unless they are grossly negligent, psychotherapists are given almost complete discretion as to what they do for clients. Others have also criticized the proliferation of pseudoscientific and unscientific psychotherapies, and the "almost anything goes" attitude among many psychotherapists (Lilienfeld, Fowler, Lohr, & Lynn, 2005).

One of the worst things about the proliferation of unsupported and fringe therapies is the damage they do to the reputation of counseling and psychotherapy as professions (Lilienfeld, 1998). Unless counselors, psychotherapists, professional organizations, and state licensing boards censure such therapies, the public will probably assume that they are safe, legitimate and effective. Conscientious counselors and psychotherapists have a responsibility to practice the highest quality therapies with the most evidence of their effectiveness. Likewise, professional organizations have a responsibility to educate the public regarding which therapies are well supported and which ones are unsupported or potentially unsafe and should be avoided.

Cautions Regarding Lists of Unsupported Therapies

Although some therapeutic approaches have clearly demonstrated that they can be dangerous, such as rebirthing, others are thought to be only potentially harmful. Eventually some of the currently unsupported therapies may be shown to be safe and effective. Psychotherapists should be open minded and willing to consider new approaches when their worth is demonstrated.However, those who use unsupported therapies have the burden of proof that they are safe and effective, and until such evidence is provided, they are probably best avoided.

Listing poorly supported therapies will always require difficult judgments, since there are many types of evidence. Many fringe therapies have only anecdotes or testimonials to attest to their worth, but others have case studies or small client satisfaction surveys. While randomized, controlled studies continue to be the gold standard for research in psychotherapy, many other designs can provide valuable information.

Some therapies should be avoided simply because they are beyond the accepted scope of practice of psychologists. For example, there may be some therapeutic value in acupuncture, homeopathy, or massage, but psychotherapists who practice such treatments as part of psychotherapy could be practicing outside the bounds of their competence, and beyond the scope of standard psychotherapy practice.

Lilienfeld (2007) defined treatments as potentially harmful if they have demonstrated harmful effects in clients or others; the harmful effects are enduring; and the harmful effects have been replicated by independent researchers. He pointed out that a treatment's absence from a list of potentially harmful treatments does not mean it is safe; it may simply not have been adequately investigated. New therapies, and new variations on older therapies, are constantly being created, and it would be a challenge for list-makers to keep up with them. Also, even a potentially harmful treatment probably does not harm all clients who participate in it. It is also important to note that lists of potentially harmful therapies should be considered provisional and subject to change as further research is conducted.

Lists of Treatments to Avoid

A survey of the professional literature found several books and articles that have listed or described psychotherapies that are unsupported, probably ineffective, and/or potentially harmful. This information is presented in Table 1. This is not a complete list; only the most authoritative sources in the psychological literature have been included here. Readers should consult the authors of the lists for more information and clarification regarding the reasons for why the authors listed specific treatments. It should be noted that a few therapies, such as EMDR, have been described as poorly supported by some writers and as well supported by others. Citations for sources are given beginning with the most recent.

Table 1

Psychotherapies That Are Unsupported, Probably Ineffective, And/Or Potentially Harmful

Cummings, N. A. & O'Donohue, W. T. (2008).
Rebirthing
Treatment for trauma induced by alien abduction
Jungian dream interpretation
The use of children's drawings to diagnose sexual abuse
Treatment of "depression" that is really just the blues and normal mood swings
Grief counseling when used as a blanket intervention after a crisis
Treatment of PTSD when applied to civilian situations instead of combat situations
Therapy to help patients recover memories of incest
Rebirthing (attachment) therapy
Eye Movement Desensitization and Reprocessing (EMDR)
Treatment for dissociative identity disorder
Psychoanalysis
Psychotherapy to assist clients with self-actualization
Crisis counseling
Mindfulness interventions
Meditation
Acceptance and Commitment Therapy

Commission for Scientific Medicine and Mental Health, (n.d.).
Untested herbal medicines
Homeopathy
Aromatherapy
Acupuncture
Therapeutic Touch
Prayer at a distance
Faith healing
Facilitated communication
Hypnotic age regression

Lilienfeld, S. O. (2007).
Provisional List of Potentially Harmful Therapies
Level I: Probably harmful for some individuals
Critical incident stress debriefing
Scared Straight interventions
Facilitated communication
Attachment therapy (e.g., rebirthing)
Recovered-memory techniques (e.g. hypnosis; guided imagery)
Therapy for dissociative identity disorder (DID) (multiple personality disorder)
Grief counseling for individuals with normal bereavement reactions
Expressive-experiential therapies (e.g. focused expressive psychotherapy; gestalt therapy; encounter groups)
Boot-camp interventions for conduct disorder
Drug Abuse and Resistance Education (DARE) programs
Level II: Possibly harmful for some individuals
Peer-group interventions for conduct disorder
Relaxation treatments for panic-prone patients (e. g, progressive relaxation; meditation)

Coelho, H. F. (2007).
Energy psychology therapies
Thought Field Therapy

Norcross, J. C., Koocher, G. & Garofalo, A. (2006).
Certainly discredited treatments:
Angel therapy
Use of pyramid structures
Orgone therapy
Crystal healing
Past lives therapy
Future lives therapy
Treatments for post-traumatic stress disorder caused by alien abduction
Rebirthing therapies
Color therapy
Primal Scream therapy
Thought Field Therapy
Aroma therapy
Probably discredited treatments:
Erhard Seminars Training (*est*)
Age-regression methods for adults who may have been sexually abused as children
Craniosacral therapy or treatment of anxiety and depression

Preventive intervention for "born criminals"
Sexual reorientation/reparative therapy for homosexuality
Holding therapy for reactive attachment disorder
Treatments for mental disorders resulting from Satanic ritual abuse
Healing touch (not massage therapy) for treatment of mental/behavioral disorders
Psychological treatments of schizophrenia based on the schizophrenogenic theory
Reparenting therapies for treatment of mental/behavioral disorders
Bettelheim model for treatment of childhood autism
Dolphin-assisted therapy for treatment of developmental disorders

Examples of possibly discredited treatments

Equine therapy for treatment of eating disorders
Neuro-Linguistic Programming
Psychosynthesis
Scared Straight programs
Emotional Freedom Technique
DARE programs
Rage reduction therapy for depression
Bioenergetic therapy
Insight-oriented psychotherapies for sex offenders
Catharsis/ventilation treatment for anger disorders
Marathon encounter groups
Acupuncture for the treatment of mental/behavioral disorders
Critical Incident Stress Debriefing for acute trauma
Psychosocial therapies for treatment of pedophilia
Neurofeedback for attention deficit hyperactivity disorder
Classical psychoanalysis for removal of Axis I symptoms
Eye Movement Desensitization and Reprocessing

Barrett, S., London, W., Baratz, R. & Kroger, M. (2006).
Auditory Integration Training
Doman-Delacato Treatment
Eye Movement Desensitization and Reprocessing (EMDR)
Facilitated Communication
Neural Organization Technique
Neuro Emotional Technique
Neurolinguistic Programming
Neurotherapy
Past-Life Therapy
Stimulation of false memories
"Energy therapies:" Thought Field Therapy, Emotional Freedom Technique, Tapas Accupressure Technique, Energy Diagnostic and Treatment Methods, Be Set Free Fast, Whole Life Healing

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Lilienfeld, S. O., Fowler, K. A., Lohr, J. M., & Lynn, S. J. (2005).
Attachment therapies (e.g. rebirthing)
Critical Incident Stress Debriefing
Grief therapy for normal bereavement
Peer Group Interventions for conduct problems
Scared Straight programs for conduct problems
Recovered memory interventions
Dissociative Identity Disorder – Oriented Therapy
Facilitated Communication for infantile autism and developmental disabilities
Thought Field Therapy
Energy psychology
Eye Movement Desensitization and Reprocessing

Music therapy
Aromatherapy
Homeopathy
Breath work
Therapeutic Touch
Medical intuition
Body-centered psychotherapies
Suggestive methods to recover purported memories of child sexual abuse (such as hypnosis, guided imagery, dream interpretation, free association to childhood memories, journaling, interpretation of ambiguous symptoms, trance writing, and body work)
Most self-help and recovery books (e.g. *Courage to Heal*)
Purported self-help "experts" on television and radio (e.g. Tony Robbins)

Mercer, J., Sarner, L., Rosa, L, & Costa, G. (2003).
Attachment therapy
Rebirthing
Patterning
Compression therapy; some forms of holding therapy
Treatments using coercive restraint with children

Lohr, J. M., Hooke, W., Gist, R. & Tolin, D. F. (2003).
Eye Movement Desensitization and Reprocessing
Thought Field Therapy
Critical Incident Stress Debriefing

Singer, M. T. & Nievod, A. (2004).
Recovered memory therapy
Therapy for Satanic ritual abuse
Therapy for evil entities
Rebirthing and re-parenting therapy
Past life therapy
Some therapies for dissociative identity disorder
Thought Field Therapy
New Age therapies

Lilienfeld, S. O. (2002a).
Sleep-assisted learning techniques
Subliminal audiotapes
Hemispheric synchronization devices
Herbal remedies for enhancing memory or mood
Thought Field Therapy
Imago Relationship Therapy
Calligraphy therapy
Neurotherapy
Jungian sandplay therapy
Critical Incident Stress Debriefing
Rebirthing therapy
Suggestive techniques to recover purported memories of satanic abuse & alien abduction

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Lilienfeld, S. O. (2002b).
Facilitated communication
Sensorimotor integration for autistic disorder
Neurofeedback (EEG biofeedback) for attention-deficit/hyperactivity disorder
Alcoholics Anonymous and Twelve-Step programs for other addictive problems

Eisner, D. A. (2000).
Recovered memory therapy
Thought Field Therapy
Eye Movement Desensitization and Reprocessing (EMDR)
Primal Scream therapy
Neurolinguistic programming
Rage reduction therapy
Angel therapy
Emotional Freedom Technique
Silva method

Singer, M. & Lalich, J. (1996).
Reparenting, and rebirthing
Age regression therapy using hypnosis
Past-life and future-life therapy
Entities therapies
Channeling
Therapy for stress related to purported alien abduction
Some forms of cathartic therapy (emotional ventilation)
Primal Scream therapy; New Identity Process; Bio Scream Psychotherapy
Neuro-Linguistic Programming
Facilitated Communication
Neural Organization Technique
Eye Movement Desensitization and Reprocessing (EMDR)

Conclusion

Considerable energy has been devoted to identifying empirically supported treatments, and now attention needs to be directed to identifying treatments that are potentially harmful (Lilienfeld, 2007). Current research shows that some treatments are effective and others are harmful. Some therapies should probably be avoided unless and until they have at least a minimal amount of good research that establishes their safety and effectiveness. Although it will be challenging and controversial to establish a list of such therapies, many psychologists, such as those cited above, think the effort is worthwhile. Counselors and psychotherapists could use a list of treatments to avoid as well as already published lists of evidence-based treatments to help them select interventions to use with clients who have clearly defined disorders. Counselors have more leeway for selecting treatments if the client's disorder does not have an indicated treatment on the lists of evidence-based and empirically supported treatments. If considered carefully, lists of both empirically supported treatments and treatments to avoid can provide valuable guidance for counselors and psychologists (Castonguay, Boswell, Constantine, Goldfried, & Hill, 2010).

Support for the safety and efficacy of treatments to avoid may be established in the future, at which time the lists should be revised. Professional organizations such as the American Psychological Association and the American Counseling Association should not approve continuing education training in unsupported and potentially dangerous treatments, and should encourage counselors and therapists to avoid them until their safety and efficacy is established. Professional organizations should also establish practice guidelines that would help counselors select safe and effective treatments and avoid potentially unsafe and ineffective treatments.

This paper provides a tentative beginning to stimulate discussion on this topic. It should be emphasized that the intent of compiling lists of empirically supported and empirically unsupported treatments is not to limit the options of counselors, but rather to increase the likelihood that clients will receive safe and effective treatment. Currently, with very few exceptions, counselors can practice any psychotherapeutic treatment they like. Presumably counselors and psychotherapists who have their clients' well-being as their highest priority would approve the suggestion to avoid treatments that have not yet established their safety and effectiveness.

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Study of Graduate Student Perceptions at The University of West Alabama.

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Abstract

With the increase in the number of online graduate programs available and economic considerations, small, rural universities have to be concerned about a possible decline in their on-campus enrollment. This study examines those factors that effect students' decisions to take on-campus classes that can impact recruitment of on-campus students. Participants included both MEd and MSCE students (n = 90). The researcher team-constructed instrument consisted of seven variables associated with graduate student choice. The study found that the financial cost of the program was the only significant variable.

Introduction

Current literature related to why graduate students choose on-campus graduate programs at rural universities versus online course classes is, at best, scarce. During the last decade, graduate admissions officers, recruitment personnel, college administrators and university faculty members have worked to attract more graduate students to their respective rural universities. Online graduate enrollment growth at rural universities has often dramatically outpaced traditional, on-campus enrollments (Beard, Harper & Riley, 2004). For the purposes of this study, 'rural university' is defined as a university that serves a small population, is remotely located in a non-urban area, and functions with limited resources due to deficient economic and social conditions. As a result, a new paradigm has emerged; traditional or on-campus graduate offerings of courses is growing at a lower rate or even declining while on-line offerings are increasing. The Sloan Consortium report (2008) noted a 17 % increase in online enrollment for 2008 for a total of 4.6 million students. Furthermore, Parry (2010) reported:

> Seventy-three percent of institutions report increased demand for existing online courses, compared with 54 percent for face-to-face. Sixty-six percent report increased demand for new online courses. And students are clamoring for distance education at colleges that don't offer it; 45 percent of institutions in that category report growing demand for new online courses and programs (Summary).

Review of the Related Literature

Examination of variables in this research project led to the following areas of investigation: selecting a graduate institution, the role of recruitment in graduate programs, web-based andtraditional instructional choices and learning, and school counseling programs on campus and online.

Selecting a Graduate Institution. Enrolling in online graduate programs can be a positive experience; however, distance education is not the best choice for all students. Some adult learners excel in an online graduate program while others prefer the traditional, on-campus route. Online learning is considerably different from its face-to-face counterpart (Bennett & Lockyer, 2004; Conrad, 2004). In 2008, an increase of 12.9% in students completing at least one online course over the prior year exceeded the increase of 1.2% overall within the higher education population during the same time period (Allen & Seaman, (2008).

professor-student relationships, on campus learning formats versus online learning formats, need for feelings of association with campus life, and the degree of structure needed. The individual seeking a graduate program in counseling should consider the critical academic factors, as well as the critical non-academic factors involved in the selection. According to Lei and Ning-Kuang (2010), a variety of demographic factors influence the selection; these include age, gender, ethnicity, socioeconomic status, citizenship, marital status and enrollment status. The decision-making process can provide students with opportunities to locate and pursue their particular field of study, to find the best fit for their strengths and talents, and to determine what their educational needs will be (Poock and Love, 2007). Graduate students must also meet the requirements of the program to which they are seeking enrollment; therefore, they might decide on a program or institution which has certain scores on standardized tests and grade point averages; favorable living/travel expenses; opportunities for peer interactions, and local job opportunities (Lei and Ning-Kuang, 2010).

The Role of Recruitment in Graduate Programs. Quarterman (2008) examined barriers and strategies to recruit and retain a diverse graduate student population. His qualitative investigation included surveys from university administrators. Barriers to recruitment included "the need for planned recruitment and retention programs, the lack of financial resources and an insufficient pool of eligible students" (Quaterman, 2008, p. 2). Strategies for recruitment included "personal contact through visits, the need for recruitment fairs and career days at institutions of higher learning, and availability of financial resources" (Quarterman, 2008, p. 2). Oftentimes, diverse students fail to develop and thrive in an environment that does not provide faculty role models and mentors, adequate financial resources, and access to basic skills subject matter. The diverse students may feel alienated, isolated, and lonely, resulting in their departure from the program; therefore, retention is an aspect of recruitment. The findings of Quarterman's (2008) study indicated that it is important for college/university administrators and professors to recognize the needs of graduate students as dominant in the selection process. Understanding the barriers to recruitment at a rural university and the requirements for retention promotes the potential to increase the enrollment of graduate students in a counseling graduate program.

The university registrar has a crucial role in recruiting and retaining graduate students, particularly those individuals who benefit from inclusion (Rees, 2009). The entire faculty, staff, and administration of a university have a mandate to create a caring environment for all students at all levels. The registrar must promote and recruit diverse students; then, the students must be monitored for progress and to ensure graduation. Furthermore, the registrar must also be aware of the recent changes to recruitment. Many graduate students prefer to receive electronic information about prospective enrollment; sixty-three percent of a sample of 1,000 prospective graduate applicants preferred electronic information prior to and after enrollment (Czurak, 2009). Czurak (2009) noted that knowing what was required in the program was of the highest importance, with the availability of information on finances/funding as the second in importance.

Web-based and Traditional Instructional Choices and Learning. Web-based learning through online courses represents a paradigm shift in adult learning theories to a more constructivist approach (Moore, 2005). The complex phenomenon of web-based learning indicates changes in both work and educational environments in higher education. Traditional methods now compete with a wide range of distance education programs. Because of the rapid growth of technological possibilities, universities are now working with students who are independent of the educational institution. Virtual universities have brought educational opportunities to many students who could not find time to attend the traditional university classes. However, there are many limitations to the distance learning superstore or boutique. The impetus to join the marketplace in distance learning has created situations where courses proliferate with apparent cause and effect on the graduate programs offered in the traditional classrooms. According to Sloan-C Online Survey Report (2003), 81% of all institutions offer one online or blended course, while complete degree programs are found at 34% of all institutions.

Twigg (2001) reported that online courses are usually designed to deliver instruction in the same ways as traditional courses, creating a new set of problems in instructional planning. Online courses should be based on the individualized instruction of students to improve the quality of their learning. The courses should reduce student costs and provide sustainable innovations in approaching the needs of the online learners.

According to Beaudoin (2003), one of the significant areas of change as a result of the availability of online learning opportunities is the need for a change in the leadership practices of stakeholders in the traditional university classes. Situational leadership is no longer sufficient to induce graduate students to attend on campus classes (Beaudoin, 2003).

The debate between online classes and traditional university classes is often an interior dialogue among graduate students seeking to complete a degree. There are a number of personal factors that affect the graduate student's decisions; he or she must decide, for instance, whether he or she needs face time with an instructor in a traditional setting or whether face time is a non-essential. The graduate student must consider his or her family status and job or career status and whether he or she will be distracted while trying to study or be involved in class work. Also, the graduate student must consider whether he or she has the patience and discipline to complete the work within the specific class deadlines. It is easier to become distracted, or to put off online assignments when there is no direct supervision. A final thing to consider is the degree of satisfaction one will derive from taking an online class (McAllister, 2008).

Jennings (2009) also explored the differences between online and traditional classes, recommending that students spend time exploring their learning styles and specific and individual needs in the areas of time, communication/discussion, course materials and the credibility of the professors. When the graduate student considers time for traditional classes, there is a schedule for class attendance that is mandated; online students, on the other hand, have no deadlines on attendance. For a graduate student who needs personal interaction and communication, the online class may not provide enough contact to meet her or her needs. In traditional classes, students receive answers to questions immediately; in online classes, the student must wait until the response to a question is posted in a discussion board. With regard to course materials, many of these are downloaded for online courses as text, audio, or video. Traditional classes often provide many of the same materials; however, there may not be enough discussion about the materials for online students and fewer explanations. The ideal is that both traditional and online courses have credentialed professors who are credible. Legitimacy of professors is a crucial factor in the value of the course to an individual's future. According to Jennings (2009) the expectation is that students will continue to debate the merits of both online and traditional courses in order to make effective personal decisions.

School Counseling Programs on Campus and Online. An example of a carefully designed program came from three universities in western Canada who worked together to create an applied counseling initiative that is delivered by web-based technology (Collins & Jerry, 2005). The structure of the program (The Campus Alberta Applied Psychology: Counseling Initiative (CAAP) was designed to provide "a predominately Web-based alternative for individuals seeking graduate level training in counseling psychology" (p. 100). Unique qualities of the program were the collaborative nature of the undertaking, the first web-based program in the counseling/psychology area in Canada, and the ways that students in the work force could utilize the degree program. The program was developed after a survey revealed 800 individuals were looking for an online program to allow them to continue working and meeting their personal needs. This marked analysis provided the impetus to collaborate "to provide curricula, student services, library and other supports" (p. 101) from locations in four different cities. This collaboration provided a seamless delivery for the necessary services. The diploma (parchment) included the crests of all of the institutions. There are several programs under the CAAP initiative umbrella; however, the focus of this review of literature is on the counseling program. The program from CAAP is described as equivalent to "the on-campus course-based Master of Education in Counseling programs at Alberta universities, with a 12 course (36 credit) requirement, plus a final exit project that is seen as the equivalent of six credits" (p. 101). The timeframe for completion of the program is three years. The program includes practicum hours (260) but it is expected that there will be more hours included to meet Canadian and American requirements. Four courses within the program require students to meet face-to-face in summer institutes for three weeks. The costs of the program are $10,287 US. The student can pay for the program at a fixed rate over the three-year length of the program. Courses costs $1,305 US. Students in the on-campus program can also take CAAP classes if they choose. The program is accredited and the courses are transferable.

One of the most important aspects of the program is the ability to standardize the content of the courses offered. There is also a standardized process for delivery of the instructional material developed from templates created by the lead professors for the courses. Students take courses and have weekly lessons that include discussions by chat room or e-mail, as well as small group activities. Class size is limited to 20 graduate students. After the end of the first two years of the program, students reported higher satisfaction when they were taking only online courses. The CAAP is based on a highly successful on-campus counseling program that produces academic success and satisfaction for the students that are enrolled that the three universities.

Most online programs follow the design of on-campus programs in order to meet the requirements for graduation and certification as a counselor. Reform in the area of counseling has been initiated by the Education Trust's National Center for Transforming School Counseling (NCTSC) and American School Counselor Association (ASCA) National Model derived from standards put forth by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). Whether the program is presented online or on-campus the requirements of the standards remains inviolate. Counseling programs that are following the specialty standards will produce graduates who are capable of performing transformed counselor roles. Students in a study who follow the training modules developed by ASCA reported that they perceived an improvement in their preparation to meet the standards in four areas:

(a) developing school counseling programs that promote access, equity, and achievement for all students;

(b) working toward systemic change in schools;

(c) using teaming and collaboration to promote access and equity and improve student achievement; and

(d) using data to design programs and create change for typically underrepresented groups. (Wilkerson & Eschbach, 2010, p. 7)

This implies that any and all counselor programs should incorporate these areas into their course work. Through efforts to articulate the role of the school counselor, organizations have developed stronger standards to insure that professionals have the skills they need to perform their functions effectively. Regardless of the choice by graduate students to take courses online or on campus; the outcome should be improved counseling for students.

With the rising enrollment in online programs, the question remains why some students continue to prefer the traditional on-campus route. The absence of current studies related to rural universities raises the question: On what evidential bases are rural universities creating their marketing plans for recruiting graduate students to their respective on-campus programs? Clearly, more research is needed related to the current factors associated with attracting graduate students to the graduate programs at rural universities. The question of the decade for many rural universities appears to be "What can we do to preserve and/or grow our on-campus graduate enrollments?"

Purpose of the Study

The purpose of this study was two-fold: a) to expand the body of current literature related to on-campus graduate student recruitment at rural universities, and b) to help identify those recruitment factors which might be used to effectively recruit more graduate students to complete coursework on-campus at a rural university. The researchers entered into this study with the desire to create a dialog about the future of on-campus graduate recruitment based more on research-based evidence and less on traditionally speculative approaches.

Methodology

The researchers in this study chose to examine seven variables related to graduate student perception and influence toward taking traditionally-taught, on-campus classes at a rural university. A faculty research team created a survey instrument to assess student perception variables identified as being linked to graduate student

enrollment in on-campus classes. The survey was administered to 45 Masters in Education in School Counseling graduate students (M.Ed.) and 45 Masters in Continuing Education in Counseling (M.S.C.E). graduate students at a small rural university. Traditionally, M.Ed. students at the rural university take more classes on-campus versus their M.S.C.E. counterparts who tend to take more of their classes online. Results from the two groups were compared across the following seven graduate student perception variables: a) costs associated with taking the course, b) academic rigor, c) general learning atmosphere, d) professor-student relationship, e) on-campus offering format, f) feelings of association with campus life, and g) the need for structure.

Results of the Study

Researchers conducted both a t-test for independent means statistical procedure for each variable. Table one shows the statistical analysis of the t-test for independent means with the Levene's Test for Equality of Variances.

Table One
Statistical analysis: t-test for independent means of variables

Variable	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Sig	t	df	Sig. (2-tailed)
VAR00001 Cost	2.057	.155	2.031	91	.045*
VAR00002 Rigor	.044	.834	.746	91	.458
VAR00003 Atmosphere	.001	.980	-.175	91	.682
VAR00004 Prof-Stu	.801	.373	.188	91	.851
VAR00005 On-camp Lrn	1.940	.167	1.751	91	.083
VAR00006 Assoc Camp	.647	.423	.910	91	.365
VAR00007 Structure	.677	.413	1.072	91	.267

*Significant at $p < .05$

Findings revealed non-significant Levene Tests results for all seven variables assessed; therefore, researchers accepted findings of the respective t-tests for each variable in the interpretation of their results. For the variable "costs associated with taking the course," the data revealed a significant finding (p=.045) at the .05 level for the 2-tailed t-test. Data analyses of the variable "academic rigor" resulted in a non-significant finding (p=.458) at the .05 level. For the variable "general learning atmosphere," the data revealed a non-significant finding (p=.862) at the .05 level. Examination of the variable "professor-student relationship" revealed a non-significant finding (p=.851) at the .05 level. For the variable "on-campus offering format," the data revealed a non-significant finding (p=.083) at the .05 level. Data analyses of the variable "feelings of association with campus life" resulted in a non-significant finding (p=.365) at the .05 level. For the variable "the need for structure," the data revealed a non-significant finding (p=.287) at the .05 level.

Summary and Implications

The results of this study suggest that, with the exception of costs, the other variables examined by the researchers did not appear to significantly influence student perceptions about taking on-campus graduate classes. The findings match the research by Lei and Ning-Kuang (2010) which included favorable living/ travel expenses. This also agreed with the research of Collins and Jerry, 2005; McAllister, 2008; Quaterman, 2009; and Twigg, 200l, who reported that cost was associated with the selection of an online or on-campus program. Rural universities seeking to improve their on-campus graduate enrollments should pay attention to

the entire student financial costs associated with taking an on-campus class (tuition, books, fees, etc). These schools should also collect more information about their on-campus graduate students (i.e. average distance travelled to class, how much tuition they can afford, etc.) and ensure that adequate on-campus support systems are in place to encourage students who choose to make the commute. The body of literature and evidential research should be expanded to help rural universities in their quest to retain, grow and make informed recruiting decisions in the best interest of their on-campus graduate programs.

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APPENDIX

ON CAMPUS SURVEY

In the identification section, circle the number by the response corresponding to the letter of each item that best identifies your response.

1. What is your gender?
   a) Female b) Male

2. What degree are you pursuing?
   a) M.Ed. b) MSCE c) MAT certification d) MAT (non-certification)

Read each statement and select the number that represents most closely the degree of influence the item had in your decision to earn your degree online.

1. Strongly influenced
2. Influenced
3. Neither influenced or not influenced
4. Had no influence
5. Strongly had no influence

I chose to take my courses at the University of West Alabama on campus because:

1. The cost of on campus courses is cheaper than courses online.	1	2	3	4	5
2. Courses offered on campus are easier than courses online.	1	2	3	4	5
3. I enjoy the classroom atmosphere (discussion, group work).	1	2	3	4	5
4. I like the professional relationship I can have with my professor.	1	2	3	4	5
5. I like the format of the class better than online.	1	2	3	4	5
6. I feel more a part of the campus life	1	2	3	4	5
7. I would have difficulty structuring my time in an online class	1	2	3	4	5

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