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Editors

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From *the* Editors

Counter-Transference, Values and the New ACA Code of Ethics: Making Progress?

Changes to the most recent American Counseling Association (ACA) Code of Ethics (2014) have initiated an entirely new way of dealing with the process of counter-transference as it relates to protecting the client from the imposition of values from their counselor. The purpose of this article is to examine these changes and the possible implications for counselors these changes may have on the basic nature of the counseling relationship.

Changes

The first change provides the counseling profession with clarification and guidance when counselors determine that he/ she has a stark values difference with their client. This is especially true when that difference may preclude them from establishing the unconditional positive regard (UPR) that Rogers viewed as essential to therapeutic growth. Previous codes of ethics from the American Counseling Association (ACA, 1997 and 2005) did not impose a requirement or suggest a course of action for the counselor to pursue that was ethically appropriate

1997 Section A: A.5.b. *Personal values*
> *Counselors are aware of their own values, attitudes, beliefs, and behaviors and how these apply in a diverse society, and avoid imposing their values on clients. (ACA 1997)*

2005 Section A: A.4.b. *Personal Values*
> *Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals.*

> *Counselors respect the diversity of clients, trainees and research participants.*

2014 Section A: 4.b. *Personal Values*
> *Counselors are aware of –and avoid imposing – their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants **and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.***

This mandate to seek training in the most current ACA code of ethics (2014) finally gives a specific remedy to the values conflict counselors can experience in the counter-transference process.

A second change to the 2014 Code is found in a new section previously not referenced in prior codes, Section A.11.b. This section prohibits the counselor from referring a client when the counter-transference issues of values conflicts is the only basis for the referral.

2014 Section A: A.11.b. *Values Within Termination and Referral*

> *Counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs, and behaviors.*
>
> *Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.*

This new requirement suspends the counselors previously allowed ability to refer a client if the issues of counter-transference involving values precluded their self-assessed ability to maintain UPR for the client.

Impact on the Counseling Relationship

One of the basic tenets of all counseling relationships that facilitate "psychological growth" (1961, Rogers, p.61) is that the counselor must exhibit unconditional positive regard (UPR) (1961) toward every client. This means that the counselor "prizes the client in a total rather than conditional way" and that the counselor "does not simply accept the client when he is behaving in certain ways, and disapprove of him when he behaves in other ways" (p62). Rogers and all the research since further concludes the UPR that the counselor develops toward the client greatly impacts therapeutic change, while the methods the counselor employs are of minor consequence (1961). Counter-transference issues involving the values of the client creates "an insidious obstruction to the analyst's benevolent neutrality" (Gay, 1988,p. 253) making UPR almost impossible.

Counselors that have values conflicts making it difficult to have unconditional positive regard due to counter-transference issues has been realized by the ACA codes of ethics for some time (2014, 2005, & 1997). The need for the counselors to get remediation in some form has also been a matter of focus by the profession for years. The current code (2014) has drastically changed the process of remediation for the counselor in two ways.

First, the recommendation that counselors get "further training" on matters of values conflicts goes beyond direction in previous codes and lessens the "inherent ambiguity" (Dass, 1988) in the counseling relationship. This allows for some standardization in the expectation of how counselors are to deal with these issues of counter-transference. Such standardization would include the expectation that the counselor to seek training in such situations. It would also create a need to expand the offerings for training in this area to accommodate counselor's demands in needing more diverse training opportunities in values. Both the standardization of the actions counselors are to take in such situations and the possible expansion on training to meet new needs seem like positive steps toward professional growth in the profession and the professional dealing with new diversity issues.

Second, previous codes did not specify that the therapeutic relationship was to continue while the remediation for the counselor transpired. This would allow the counselor to refer the client to an appropriate professional while they worked on their values issues allowing them to become effective with future clients. Examining the new values (Moral Principles 1995) that the code of ethics is predicated upon raises some concerns about having the counselor maintain a relationship while knowingly not being able to provide an essential element of the therapeutic process to the client. First, is the counselor exhibiting fidelity when he or she is not fulfilling their responsibility to bring all qualities of the therapeutic relationship to the session, namely, the element of UPR needed to create an appropriate helping relationship? Second, is the counselor practicing beneficence and nonmaleficence? The authors ask that ACA ponder the possible legal implications of a

counselor continuing a counseling relationship that is not beneficial at best and harmful at worst. If countertransference issues prevent the counselor from being able to provide the qualities necessary for a beneficial therapeutic relationship, it may be wise to refer the client to another professional while the counselor seeks additional training in that area.

Conclusion

Subsequent revisions of the ACA code of ethics may want to consider expanding the foundation set by the 2014 code by adding even more specific directions their remediation might take. ACA has already done the groundwork for such a revision with the inclusion of the ethical principles listed in the ACA Code of Ethics Preamble taken from "A Practitioner's Guide to Ethical Decision Making"(ACA, 1995). In the decision making guide, there are several possibilities for additional remediation directions. The first of these is to utilize the moral principles newly included in the 2014 code of ethics (p.3).

> *Autonomy* -or fostering the right to control the direction of one's life
> *Nonmaleficence* – or avoiding actions that cause harm
> *Beneficence* – or working for the good of the individual and society by promoting mental health and well being
> *Justice* –or treating individuals equitably and fostering fairness and equality
> *Fidelity* – or honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in professional relationships
> *Veracity* – or dealing truthfully with individuals with whom counselors come into professional contact

These five moral principles along with the recent addition of veracity (ACA, 2014, p3) provide the counselor with an excellent method of self-reflection and evaluation that could assist in specifically indicating what types or areas of training are needed to remediate their

own values based counter-transference issue. Future directions, may also include research to determine what types of values differences counselors may experience with clients to assist in training programs and supervisors providing needed training or continuing education.

Other suggestions for guidelines are found in the text of the decision making guide in step 3 (5-6). In addition to having the counselor apply the aforementioned moral guidelines, step 3 suggests that the counselor refer to the literature on the dilemma at hand and that he/she consult with a variety of sources including colleges, supervisors and professional organizations. Seeking supervision and consultation as a requirement in this part of the code would definitely assist the counselor in identifying and obtaining appropriate training.

Finally, ACA may wish to revisit the restrictions placed on counselors that are experiencing a need to work on themselves. The current retractions actually present a new potential dilemma for the counselor in this situation. If the research and Rogers is correct then there are going to be some values differences that create a situation where the counselor is unable to have UPR. Currently, under the new code they are mandated to keep working with a client that they are not being therapeutically effective with (A.11.b.) yet simultaneously told to terminate if they are no longer being of benefit under (A.11.c.). If the counselor isn't able to provide a proper therapeutic relationship needed to foster psychological growth are they not also in violation of nonmaleficence (ACA, 2014, p3)?

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Section I: Professionals' Articles

Supporting Mandated Child Abuse and Neglect Reporters

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Counselors and other professionals who are mandated child abuse and neglect reporters can benefit from support when making a determination about a suspected child abuse report and can provide support for other non-mental health professional mandated reporters. The authors present definitions and signs of child abuse and neglect and discuss an early childhood mental health consultation program that supports its mental health consultants (e.g., LPCs) in making appropriate child abuse and neglect reports themselves, while also helping the consultants to provide similar support to child care professionals in determining when and how child abuse reports should be made. The authors outline methods of encouraging reluctant mandated reporters, which include remaining child-focused, discussing fears and hesitations, and determining if and how a report should be disclosed to families.

Keywords: abuse, neglect, mandated reporters, mental health consultation

Counselors, psychologists, teachers, coaches, child care staff, and social workers, and many other professionals have at least one thing in common: they are mandated reporters of child abuse and neglect. This sounds simple when written, but the process of making a child abuse or neglect report is often a difficult one to navigate. Mandated reporters may find themselves in the position of trying to determine if a situation necessitates reporting, how the report may affect their relationship with the client or child's family, and if the report will be adequately investigated. All of these concerns are valid, and reporters should seek consultation and/or supervision to help answer questions. While individuals in the mental health field are often given much support and training around making child abuse and neglect reports, the process of deciding to make a report, following through with the report and working through the possible outcomes of a report, may make the situation difficult for mandated reporters.

Through our program, which provides mental health consultation to child care centers (see Heller et al., 2011 for a detailed description of our early childhood mental health consultation program), we realized that supporting our consultants, all licensed mental health professionals (e.g., licensed professional counselors or licensed clinical social workers), in making child abuse and neglect reports and helping them to support child care professionals in making reports is a primary focus of our work. Our consultants provide 4 to 6 hour visits every other week to child care centers participating in Louisiana's Quality Rating and Improvement System for child care centers, Quality Start. Participation is free for participating centers. This early childhood mental health consultation program aims to support children, teachers, and families involved in center based care, with a primary focus on supporting teachers' abilities to promote healthy social emotional development for the children in their care. A consultation agreement

is signed before a consultant begins consultation. This informed consent outlines the benefits, potential risks, alternatives, and limits to confidentiality including suspected child abuse or neglect as is required by the American Counseling Association Code of Ethics, section D.2.b (American Counseling Association, 2014).

Despite the trainings and articles that exist around understanding child abuse and neglect reporting, we found that professionals across disciplines are often anxious, ill-prepared, and/or under-educated about when and how to make these reports. Mental health professionals are better educated and more equipped to make reports than are child care teachers; however, we believe support is necessary regardless of the profession. This article will outline the guidelines for making child abuse and neglect reports, examine reasons why individuals may be reluctant to report, and offer methods of supporting mandated reporters from making the initial report to following through with the family.

Child Abuse and Neglect

Before we can discuss how and when child abuse and neglect reports should be made, it is important to understand how child abuse and neglect is defined in legal terms and how mandatory reporters are defined across the United States. The Federal government provided the minimum standards, The Federal Child Abuse and Prevention Act (CAPTA), which each state may use as a foundation to define child abuse and neglect (Child Welfare Information Gateway, 2008). Four commonly identified types of abuse are recognized in most states: physical abuse, sexual abuse, emotional abuse, and neglect. Neglect is subdivided into four subtypes: physical, medical, educational, and emotional

(The Child Welfare Information Gateway, 2007).

CAPTA defined child abuse and neglect as "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk for serious harm" (CAPTA, 2003). In the state of Louisiana, the Department of Children and Family Services (DCFS) defined physical abuse as "acts which seriously endanger the physical, mental or emotional health and safety of the child" (2014). DCFS (2014) described neglect as "the refusal or unreasonable failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment, or counseling for injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired."

Mandated reporters may identify the signs and symptoms of abuse or neglect through physical markings or patterns of behaviors. The Child Welfare Information Gateway (2007) stated abuse signs may include "unexplained burns, bites, bruises, broken bones, or black eyes" (p. 3). Neglect may be suspected when a child is "frequently absent from school; begs or steals food or money; lacks needed medical or dental care, immunizations, or glasses; is consistently dirty and has severe body odor; lacks sufficient clothing for the weather; abuses alcohol or other drugs; and/or states that there is no one at home to provide care" (p. 3). Furthermore, the signs of sexual abuse may include difficulty with walking, sitting, or running; changes in appetite; unusual sexual knowledge or behaviors; and/or other changes in behavior. This may include refusal to participate in activities that would include changing clothes, such as gym

class. Additionally, the child may experience nightmares or bedwetting. Children who are emotionally abused may show the following signs: extreme behaviors (e.g., overly compliant, demanding, passive, or aggressive); adult-like behaviors (e.g., parenting others); delays in emotional development; or a lack of attachment (The Child Welfare Information Gateway, 2007).

The Children's Bureau (2010) reported that approximately 3.3 million referrals, (i.e., initial reports or screenings) across the United States were received during 2010. These referrals may be "screened in" or "screened out". During 2010, Children's Bureau reported 1,581,882 screened in reports and 1,025,916 screened out reports for a total of 2,607,798 reports. The screened in referrals are then substantiated or unsubstantiated. A substantiated report is one in which the allegation of abuse or neglect met the requirements for abuse or neglect as defined by law in a specific state (Children's Bureau, 2010). According to the Children's Bureau 436,321 reports were substantiated in the United States during 2010. Alternatively, unsubstantiated reports were determined to not demonstrate evidence indicative of abuse or neglect according to that state's law. During 2010 1,262,118 reports were unsubstantiated across the United States (Children's Bureau, 2010). Some states have alternative categories such as: intentionally false, closed with no findings, or other. Reports are categorized according to report source: professional (i.e., child care providers, educational personnel, foster care providers, legal and law enforcement, medical, mental health professionals, social services); nonprofessional (i.e., alleged perpetrators, alleged victims, anonymous sources, friends and

neighbors, other relatives, and parents); and Other/Unknown. During 2010 the Children's Bureau received 1,130,071 referrals from professionals, with mental health professionals reporting 89,344 of those referrals.

Mandatory reporters of child abuse vary slightly from state to state. In approximately 18 states, any person who suspects abuse or neglect is mandated to report; however, across 48 states mandated reporters typically include: social workers, teachers and other school personnel, physicians and other health-care workers, mental health professionals, child care providers, medical examiners or coroners, and law enforcement officers (Child Welfare Information Gateway, 2008). In most states, a report must be made upon the suspicion of abuse or neglect (Child Welfare Information Gateway, 2010). While privileged communication allows practitioners to maintain confidential communications with their clients, most states limit privileged communication to assure protection of maltreated children, and mandate reports of suspicions of abuse or neglect (Child Welfare Information Gateway, 2010).

How a report is filed varies from state to state. This information is typically provided by local police departments and/or child protective services (Child Welfare Information Gateway; 2008). The National Childhelp ® National Child Abuse Hotline number is 1-800-4ACHILD. Alternatively, mandated reporters may locate their state hotline or a national crisis line at http://www.childwelfare.gov/organizati ons/ (Child Welfare Information Gateway, 2012). In the state of Louisiana the *Confidential Department of Children and Family Services/Child Welfare Written Report Form for Mandated Reporters of Child Abuse/Neglect* may be retrieved from

http://www.dss.state.la.us/assets/doc
s/searchable/OCS/CPI-2.pdf

Reluctant Reporters

Mandated reporters may be reluctant to report; we encounter those who are resistant for numerous reasons. For example, professional school counselors have many questions about abuse or neglect reporting, including who to call; if the principal should be involved or warned; the legal responsibilities of an unsubstantiated case; what information is needed to make a report; and how to handle parent interactions about the report (Lambie, 2005). School counselors may also have concerns related to working within a school system such as encouraging school personnel to report or school personnel not being allowed to report by the principal (Bryant & Baldwin, 2010). Similarly, in our work, child care professionals often ask their mental health consultant for assistance in determining whether or not a report should be made; who should make the report (e.g., the teacher, the consultant, or the director-all are mandated reporters), and if and/or how the report should be disclosed to parents among other concerns.

Among mental health professionals, there is also confusion. When a group of licensed psychologists were presented with vignettes about child abuse and neglect reporting, they commonly cited their rationale for not reporting abuse or neglect as the desire to treat the individual with therapy. Further, they worried how a report of suspected abuse or neglect would impact on-going therapy (Renninger, Veach, & Bagdade, 2002). In another study, counselors worried that reporting suspected abuse or neglect would damage the therapeutic relationship and wondered about the thresholds of reportable suspicions (Bryant and Baldwin, 2009). Renninger, Veach, and Bagdade (2002) indicated that they were concerned that the psychologists participating in their study did not fully understand the mandates or their obligations under the law, which may directly cause negative effects for children in neglectful or abusive situations.

Seeing the need for increased support for mental health professionals tasked with reporting suspected child abuse or neglect, Lambie (2005) called for resources for mandated reporters due to their perceived hesitation and uneasiness around reporting abuse and neglect. In agreement, Renninger, Veach, and Bagdade (2002) put forth that agencies and private practices would benefit from written policies on how to handle suspicions of abuse or neglect. The recommendation for policies included consulting with a supervisor, a director, or directly with Child Protective Services. Mandated reporters would also benefit from a checklist, which could be completed prior to making the report to child protective services to assure thoroughness (Lambie, 2005). Uniform reporting forms are available and required through some states, which may make the reporting process smoother (e.g., see Louisiana's form at http://www.dss.state.la.us/assets/doc s/searchable/OCS/CPI-2.pdf).

Within our Early Childhood Mental Health Consultation program, we have a written policy for our consultants that outlines the reporting process. Within that process, the consultants are required to consult their supervisor either before reporting, if support is needed, or within 24-48 hours of reporting. We believe that supporting the mandated reporters is critical, as the reporter may need to discuss various aspects of making the report such as concerns for the family or

repercussions for the client-counselor relationship. Therefore, at least one of the four supervisors in our program is available at all times to discuss possible child abuse and neglect reports. Lambie (2005) discussed the possibility of counselors expressing feelings about perpetrators, such as "a sense of outrage, disgust, sadness, or disbelief" (p. 10). It is essential for a reporter to have an outlet to discuss these types of feelings before continuing to work with a family or client around whom a report is based.

When school counselors were surveyed, they perceived past training on mandatory reporting, knowledge of abuse, and signs and symptoms of possible abuse to be most helpful in their knowledge and comfort around child abuse and neglect reporting (Bryant and Baldwin, 2010). The survey also indicated that school counselors wanted more training related to abuse and reporting including general information about child abuse, counseling, and consulting skills, and working within the system as related to abuse and neglect reporting (Bryant & Baldwin, 2010). Counselors expressed annoyance with working within the system such as, understanding what evidence is required for a report to be validated, understanding policies within their state, and the chain of events after reporting. Additionally, counselors were frustrated with the reporting process, working with child protective services, experiences and perceptions of child protective services, and reporting in a school system (Bryant & Baldwin, 2010). Past experiences with reporting can negatively impact the reporter's view of the system as it did for some of the participants in the Bryant and Baldwin (2012) survey of school counselors. These frustrations are similar to many that we hear during reflective supervision with the early

childhood mental health consultants in our program. An additional obstacle that consultants from our program consistently noted is that many child care professionals tell the consultant that they are hesitant to report because they believed what happens within a family is "not their business" or that within their community it is not acceptable to report information to authorities. However, consultants also reflected positively upon the process of supporting child care professionals as the teacher works through her feelings about reporting and weighs the pros and cons of making a report.

Herman (2002) surveyed counselors who had encountered legal issues during the last 12 months about their perceptions of these issues. Determining if a report should be made about suspected abuse or neglect was second most common legal concern reported. Across venues, counselors encountered events that required them to consider reporting abuse or neglect, and they often had questions or needed support before making the telephone call (Herman, 2002).

As mental health professionals in schools, counselors often must serve in the supporting role for teachers who make child abuse and neglect reports. The American School Counselor Association (2003) position statement was that counselors should support staff and school personnel in making reports of suspected child abuse or neglect. Unfortunately, many of the child care centers with which we work do not have a counselor on staff, therefore the child care staff typically rely on each other for support during mandated reporting. In our state, those centers receiving early childhood mental health consultation may reach out to their consultants; however, our program serves approximately 20-25% of child care centers participating in the Quality Rating and Improvement (QRIS)

system at any one point in time. Moreover only centers participating in the QRIS are eligible for MHC services meaning that many mandated reporters in the child care field, such as family child care home providers do not have access to a consultant for this type of support.

Supporting Through Reporting

Through our early childhood mental health consultation program we identified several steps that we find helpful to support our consultants when it is necessary to make a child abuse report and/or to support early care and education professionals in making child abuse or neglect reports. We developed and view these steps through the early childhood mental health consultation lens of the "consultative stance" (Johnston & Brinamen, 2006), in which we aim to work together through our relationships to arrive at the best solution to a difficult situation.

In the first step, which is central to our work and to most mental health endeavors, we seek to partner with the mandated reporter around the present issue. With our reflective supervisees, we often already have a long-term relationship; therefore, the partnering step is taken for granted. For mental health professionals in the field, this relationship may not yet be formed, and new relationships may be tenuous and stressed by the prospect of making an abuse or neglect report. Often a mental health professional can join with the mandated reporter around the experience of the child by asking questions such as, "I wonder what is like for the child to go home at night?"

Secondly, to fully support the mandated reporter, it is important that he or she not feel threatened into making a report. This is a fine line to walk, as in many cases the mental health professional will need to attempt to make a report if the person who has first-hand knowledge of the incident does not. However, our ultimate goal is for the mandated reporter to understand their role as a mandated reporter and to support their skills in reporting so that they will be able to independently make suspected abuse and neglect reports in the future.

Language and culture are important to consider throughout the steps. To appropriately partner and encourage a child abuse report in a non-threatening manner, race, language, socio-economic status, cultural mores, and the possibility of a staff member having a history of abuse or neglect must be considered. For example, a male, Caucasian mental health consultant working in a primarily female operated, African-American child care center must consider how his gender and race may affect his relationship with the center staff. A young, African-American, female teacher may feel inappropriately pressured into following through with a child abuse report, because of difficulty she may have in stating her opinion with someone who is so different than she is and who may represent for her the opinion of the social majority. It is often the mental health professional's duty to broach the subject of cultural and social differences as the client may not feel comfortable enough to discuss these charged topics.

Discuss Fears and Hesitations

If a relationship has developed and the mandated reporter feels his or her experience is validated, there is often a natural progression to the discussion of what a child abuse report may mean to the reporter or the reporter's organization and how those concerns may contribute to a hesitation to report. Many individuals who are subordinate to a principal or director are instructed to not make child abuse reports without the express permission

of their superior. We believe that this is a detriment to the process of child abuse reporting and that it often leads to reports not being made. While it may or may not be the supporter's role to challenge this type of directive, it is important to discuss with the mandated reporter and to support the mandated reporter in navigating what is often a delicate balance between following mandated reporter laws and following internal organization requirements. At these times, the consultant may be able to represent the viewpoint of several staff members to an organization leader or may be able to facilitate a discussion between a teacher and child care center director about a reportable incident or concern. It is the hope of the consultant and our program that these types of discussions may support organizational change around appropriate child abuse and neglect reporting.

There are many other fears or hesitations that mandated reporters may have. The supporter must be able to sit with the reporter, withhold judgment, and listen to his or her perspective. For example, in our program a child care center director may be concerned that if she reports suspected child neglect that the family will remove the child from the child care center. If the center is struggling with enrollment, this could directly affect the director's ability to make payroll that month and even the center's ability to remain in business. Another concern that a center director may have is retaliation from the family. Center directors may wonder if the family will spread rumors in the community that the child care center staff make false accusations which lead to children being erroneously removed from their homes. These are often valid concerns for a child care center director to have. It is at this point that the supporter, such a mental health

consultant in our program, should reach out to a supervisor or for a professional consultation.

Consultation/Supervision for the Supporter

Often the supporter will need to make use of their own supervision to reflect upon their role in the situation and to assess if their own viewpoint has been skewed. This step is an extremely important one. As relationships between school counselors or school social workers and the teachers they serve develop across time, it can become difficult to disentangle oneself from an organization, and make more objective decisions about child abuse and neglect reporting. For example, a teacher and a school counselor may have been working together to reach out to and support a parent. If the parent has just begun to communicate with the school and the teacher and counselor are excited to begin to work more closely with her and the child, it may be very difficult for both professionals to make a suspected abuse report. Through consultation or reflective supervision the counselor may be able to more objectively view the situation and recalibrate their viewpoint to see that a report is mandated even though the parent has recently engaged with the school.

Making the Report

We found that there are three main points that our consultants highlight for child care professionals who are making a child abuse or neglect report. They encourage the mandated reporter to: remain child-focused; remember they do not need to decide whether or not abuse or neglect actually occurred; and to trust that the system will work the best that it can. The fears and hesitations that mandated reporters typically have are often not child-focused- concerns about

loss of income for the center, for example, do not consider the experience of the child. Other hesitations may be primarily child-centered. For example, a teacher may be concerned that if the child care center initiated a child neglect report that the child may not return to the center, which the teacher considers as the only safe and consistent place in the child's life. In our mental health consultation work, there are some situations in which teachers have stated that they wash children's clothes and provide the only meals that some children receive all day. These are valid and painful thoughts for all involved. It is at these times that the supporter will work with the reporter to think about the child's daily experiences and appeal to their sense of responsibility for the child. As a responsible individual in the child's life, should they be concerned about more than the hours that the child is at the center? Does the child's time at the center negate negative experiences at home? The reporter can also be gently reminded about mandated reporting laws, but we find that having a discussion about the reality of what the child may be experiencing can lead to more long-term understanding about the importance of reporting.

Mandated reporters often feel conflicted about whether or not abuse or neglect have actually occurred. The supporter's position is to remind them that it is not their job to investigate and determine if abuse or neglect happened, but instead they are mandated to report *suspicion* of abuse or neglect. We do not aim to turn mandated reporters into over-reporters. We understand that there must be some deliberation about whether or not a report is warranted, but a thorough investigation of the situation is beyond the scope of this deliberation. If that much investigation is needed, it is probably best to report to the authorities.

The hardest part of many possible child abuse and/or neglect reports is the concern that the system will not follow through appropriately. Mandated reporters have concerns that the system will not be thorough enough, that the system will be overzealous, or that confidentiality will not be maintained. Unfortunately, in our program we have encountered some of these situations. We work with the Department of Child and Family Services to report concerns that we have on the ground level and have been able to change individual decisions to investigate reports. For example, when a teacher reported to her consultant that it appeared that no investigation had occurred in a very serious report of suspected child abuse, we were able to communicate directly to DCFS and an investigation was initiated. In another situation, where the confidentiality of the person who had made the report was breached at a local level, we were able to let the state office of DCFS know about the local confidentiality breach so that standard protocol could be maintained. While the system does not always work perfectly, it is the responsibility of individual mandated reporters and system wide programs to communicate with state agencies to support young children at risk for abuse and neglect. We feel strongly that system-wide improvements will not occur if individuals who are mandated reporters take situations into their own hands.

Disclosing the Report

It is a difficult decision as to whether or not a caregiver or parent should be involved in the reporting process, and the decision should be made on a case-by-case basis (Alvarez, Donohue, Kenny, Cavanagh, & Romero, 2005). If the reporter included the parent or caregiver in the reporting process, the mandated reporter should

explain both their legal and ethical roles around suspected child abuse or neglect to the parent/caregiver (Alvarez, Kenny, Donahue, & Carpin, 2004).

There are both benefits and disadvantages of parent or caregiver notification of suspected abuse or neglect reporting. Racusin and Felsman (1986) stated they believed it should be a question of "*when* [to inform], not *whether* to inform" (p. 488). They proposed that clinicians reinforce that the report was of a suspicion, not a proven fact, and that transparency offers the opportunity to be honest thereby allowing the possibility of maintaining a therapeutic alliance. Furthermore, an additional benefit may be that parents were afforded the opportunity to tell their side and offer a time to change behaviors prior to the investigation. More importantly, parents may feel a sense of relief in a discussion about suspected abuse or neglect as they may have been in a time of crisis, which resulted in the behavior about which the report was made (Racusin & Felsman, 1986).

In a survey of how child abuse reports were made by New York state mental health professionals, seventy-four percent of the respondents reported that they informed clients prior to making the report of suspected abuse or neglect and 84% informed the client of the report at some point. However, most reports (75%) were made without the client present during the telephone call. An overwhelming 90% of mental health professionals consulted with another person, most often a supervisor (Weinstein, Levine, Kogan, Friedman, & Miller, 2000).

We must also consider the ethics of disclosing a report of suspected abuse or neglect. Racusin and Felsman (1986) believed that withholding information about reporting created a moral rule that had to be justified and in rare instances could be temporarily kept confidential, if it would result in less harm. The authors thought it was the rare case where harm would be lessened, such as when the parent may flee with the child, however, they also stated that once parents realized the deception, they could experience feelings of anger and isolation which could damage the possibility of a therapeutic alliance and future relationships with professionals. Alternatively, a delay in notification may be necessary in certain situations, for example, if the parent was intoxicated or in crisis (e.g., suicidal) then delaying notification until the parent (and child) is safe or treated would be appropriate (Racusin & Felsman, 1986).

Conclusion

Suspecting child abuse or neglect is never something that professionals who work with children want to encounter; however, it is something that they will most likely encounter. We believe that having a plan of how to proceed, and identifying individuals that can be used as a support system help make the process as smooth as it can be. Mandated reporters need to have someone with whom they can discuss fears and hesitations, can help them remain child-focused, and support them in thinking through decisions such as disclosing the report and how best to do so. It is best if this supportive relationship can be determined in advance of a suspected abuse or neglect situation so that mandated reporters are clear about whom they can contact. Counselors working with other professionals may find themselves in the position to act in this supportive role for another mandated reporter. Additionally, it is important for counselors and other mental health professionals to examine their own thoughts and need for

consultation in mandated reporting situations.

We believe that it is important for *all* mandated reporters and mental health professionals to have an individual familiar with child abuse and neglect reporting laws, who understands the professional's own code of ethics, and can be called upon for support in difficult reporting situations. With support through child abuse and neglect reporting, more children can be protected from abuse and neglect and more families can receive services necessary to raise healthy and productive children.

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Sexual Minority Domestic Violence Victims' Experiences with Counseling and Other Social Services: A Pilot Study

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Domestic violence is an ever-increasing problem in the United States today (Balsam & Szymanski, 2005; Heintz & Melendez, 2006; Hellmuth et al., 2008; Murray & Mobley, 2007). Extensive research on this topic has highlighted the need for the establishment of social service programs throughout the county to support both victims and abusers (Balsam & Szymanski, 2005;Heintz & Melendez, 2006; Hellmuth et al., 2008; Murray & Mobley, 2007). Despite the positive impact of previous research, most studies on domestic violence focus primarily on heterosexual relationships and violence against women (Balsam & Szymanski, 2005; Murray & Mobley, 2007). There is much less known regarding female abusers or violence within homosexual relationships (Greenwood, Relf, Huang, Pollack, Canchola, & Catania, 2002). Of the existing research on homosexual relationships, much of it seems to imply that gay male partnerships are less permanent than heterosexual partnerships and there appears to be a gender bias against males and homosexuals based on traditional Western gender roles (Harris & Cook, 2003; Seelau, Seekau, & Poorman, 2003).

Research from Seelau et al. (2003) shows that much of the general public views homosexual relationships as less permanent or valid than heterosexual relationships. Laws that prevent homosexual couples from marrying or forming legally binding relationships only reinforce the idea that such relationships are not permanent or valid unions (Harris & Cook, 2003; Seelau et al., 2003). This perspective of difference and illegitimacy may also contribute to a view that abuse among gay couples is different, or less serious, than abuse among heterosexual couples. Harris and Cook (2003) highlighted this concept of differential response to homosexual domestic violence. Study participants were asked to rate a series of scenarios and to determine whether the victim should leave his/her batterer. Of the victims portrayed in the scenarios, participants reportedly ranked the gay battered partner as the least likeable. Furthermore, respondents felt more strongly about the gay partner leaving his abuser than any of the other victims in the study. The researchers suggested that this response may be due to the perceived permanency of the relationship, with the gay relationship seen as easier to leave than those of the two married victims.

In addition to social perceptions of homosexual relationships, legally same sex partnerships are not treated as equitable to marriage or "marriage-like" relationships, thus legal recourse for

abuse is often not available (Ronner, 2005). Though there has been some progress with domestic partnership laws in some local and state governments, these laws are very few and often fiercely contested (Ronner, 2005). One study (Pattaviana, Hirschel, Buzawa, Faggiani, & Bentley, 2007) found that police were less likely to respond to a call of domestic violence involving homosexual relationships, and were much more likely to report to the scene of domestic violence among a heterosexual couple. When considering the complexity and shame involved in reporting instances of domestic abuse, one could see how this lack of responsiveness by the legal system could discourage victims from pursuing legal action (Pattaviana et al., 2007; Tully, 2001). Many victims, then, may choose to stay quiet and let abusive acts go unreported (Greenwood et al., 2002; Pattaviana et al., 2007; Tully, 2001). The factors that impact how many cases of heterosexual domestic abuse go unreported each year can be similarly felt by homosexual victims, but the instances of bias within the legal system may serve to further complicate this process (Tully, 2001).

Bias against males in domestic violence roles, whether as the attacker or victim, can also have a significant impact on research and responsiveness to the issues of abuse in same-sex relationships (Harris & Cook, 1994; Seelau et al., 2003). In a study comparing instances of abuse in homosexual and heterosexual relationships, participants felt that abuse in homosexual relationships was less serious because two men were involved (Seelau et al., 2003). The male victim was not seen to be as significantly at risk as the female victim (Harris & Cook, 1994). In addition, instances in heterosexual relationships where the female was the abuser were seen as less severe than instances

where the male was the abuser (Seelau et al., 2003). Similarly, Harris and Cook (1994) found that public concern and behavioral research has focused almost exclusively on wife abuse, even though husband battering has long been known to occur. In their study of participant reactions towards domestic violence situations, the researchers found that a greater responsibility was placed on the male victim in a heterosexual relationship, which generally was considered less serious than cases involving a female victim.

These previous studies seem to point to stereotypes of aggression and definitions of abuse that have a strong bias towards males (Cruz & Firestone, 1998; Harris & Cook, 1994; Seelau et al., 2003). Cruz and Firestone (1998) explored the presence of domestic violence in homosexual relationships, as well as similarities between violence and victims' perspectives in homosexual and heterosexual relationships. They found that there are significant similarities between homosexual and heterosexual participants. The researchers again found evidence of societal bias against homosexuals, as well as a bias towards male aggression. This bias may further complicate the process of responding seriously to abuse within same-sex relationships, particularly if the abuse is seen as a manifestation of gender roles. A probability-based sample of men from a study conducted by Greenwood, et al. (2002) found that the rate of domestic violence within homosexual relationships is likely much higher than statistic*s* display. This trend may be due to the bias against male victims and homosexual relationships, with men less likely to report abuse due to fear they may be perceived as weak or that their reports will not be taken seriously by others (Harris & Cook, 2003; Tully, 2001).

Additionally, biases regarding the legitimacy of homosexual relationships may explain why there is such a significant lack of research on domestic violence within homosexual partnerships, with researchers perhaps assuming that abusive homosexual relationships are somehow easier to leave or more equitable in terms of self-defense (Greenwood et al., 2002; Harris & Cook, 2003). Harris and Cook (1994) state that there has been relatively little research on domestic violence in the context of a homosexual relationship even though there is significant evidence that physical abuse exists in both gay and lesbian relationships. The extent of abuse is unclear, as most of the studies have used nonrandom samples, often targeting individuals who have been abused. The researchers theorize that the incidence of abuse is probably about as frequent as among the heterosexual population. Operative definitions of what constitutes a "relationship" may also impact selection criteria for domestic violence studies, thereby effectively excluding homosexual relationships from the research. Such limited understandings of domestic violence prevent clinical relevancy for work with homosexual couples and thus restrict effective treatment of victims and abusers within the gay community.

Method

Using a queer theory paradigm, the primary focus of this pilot study was to identify the perceptions of sexual minority domestic violence victims' experiences with counseling and other social services, along with their perceived likelihood of engaging in counseling or other social services in the future, if needed. This theory builds both upon the feminist disagreements that gender is part of the essential self, and upon gay/lesbian studies' exploration of the socially constructed ideas of sexual acts and identities (Foucault, 2006). While gay/lesbian studies typically focus on "normal" versus "deviant" behaviors with respect to homosexual behavior, queer theory is said to expand the view to include any kind of sexual act or self-proclaimed identity that is in the non-normative sector of society. The theory's main goal is to explore the meaning of the categorization of gender and sexuality in Western society (Foucault, 2006). The author claims that an individual's identity is not stationary and therefore cannot be unilaterally categorized and labeled. The idea that one's identity consists of several complex aspects, which should not be reduced to a single aspect of their essential self, enables researchers to view identity as nuanced and open to qualitative exploration (Foucault, 2006). This method was selected due to the prevalence, as previously mentioned, of biases and stereotypes that have prevented full exploration of domestic violence issues within homosexual relationships. A queer theory framework thus considers the realities of the participants, free from societal biases or predetermined conclusions.

The research questions for this study were "How do past experiences with counseling affect sexual minority domestic violence victim's perceptions of counseling?" and "How do social support systems affect the counseling process?" These open-ended questions guided the interview protocol and subsequent analysis of participant data.

Procedures

Three different data sets were collected for this pilot study, which included two individual interviews and one observation of three individuals. The interview participants were two intimate partner violence victims who self-identified as being a member of a sexual minority. The interview

participants consisted of a Caucasian male, who self-identified as being "gay", and a Caucasian female, who self-identified as being "questioning." The observation participants were two self-identified gay males and one self-identified heterosexual male. The heterosexual male was included in the study as he was present during the observation even though heterosexual males were not the target audience of the study. The participants were selected via a convenience sampling of a pre-existing list-serve of predominantly sexual minority individuals.

The research plan was to conduct a qualitative study from a queer theory perspective in order to gain a better understanding of the study participants' experiences with counseling. Queer theory is a theoretical approach to examining culture that embraces an expanded understanding of gender and sexuality (Merriam-Webster, 2011). Simply stated, queer theory rejects what most people believe it means to be male, female, gay, or straight. Queer theory starts from the assumption that any given sexuality is natural and therefore not needing correction.

Individual interviews of the two initial participants were conducted in two rounds with each interview being transcribed between rounds. Participants were given the chance to review their interview transcripts and comment during the second round of interviews. Initial interviews were 30 to 45 minutes in length and utilized the same interview protocol. The observation for this study utilized an observation protocol and was approximately 90 minutes in length.

As this study came from a queer theory approach, the research questions were designed to explore the study participants' unique experiences with previous access to counseling and

social services, as well their potential motivation to engage in services again. Questions were based on the primary research questions. Some examples of interview questions include "How would you describe the level of support from the people closest to you?", "How, if at all, did your social support system assist you with your domestic violence issues?", "What other services, if any, have you worked with for this issue?", "What impact, if any, have your previous counseling experiences had upon you and your attitudes towards counseling?", and "How effective do you feel that your therapist was in dealing with your LGBT domestic violence issues?" Though the standard interview questions provided initial structure, each interview utilized a semi-structured format where the researcher was able to ask follow-up questions and respond to participants' unique experiences. Once the initial interviews were completed, participants were asked to review the transcript of their interview for accuracy and clarity. The participants did not offer any new information during the second interview.

The last data set came from a direct observation by the primary researcher. While a pre-planned observation was scheduled, it was not successful. The observation utilized for this study was unplanned and processing by the participants was conducted a few days after the event. Observations were conducted in a non-interactive manner to prevent researcher bias. When the observation was being conducted, the researcher documented the following types of information; (1) Event setting-description of the setting of the event, date, and time, (2) List of the participants in the event as best as possible, while not using client names, (3) List of the visual and audio observations of the event from an objective viewpoint, and (4) List of any

comments and themes discovered. The observation participants consisted of a gay male abuser, gay male victim, and a heterosexual male bystander. The event happened in a private residence.

Data Analysis

After each round of data collection, data analysis was conducted by the first author. The interviews were converted from audio recordings to transcripts for all participants. Two counseling doctoral students also coded the initial interviews. Both doctoral student co-coders were in their second year of their program of study and had taken a qualitative research design course. The first author instructed each co-coder to read through the transcription to get an understanding of the perspective prior to coding.

The analytical procedure began via open coding. This involved reading and rereading the transcripts to grasp the overall tone (Creswell, 2007). In subsequent readings, we made margin notes that captured initial impressions. We organized the themes into groups of related topics. Initially, we identified several preliminary themes, but upon further analysis it became clear that the themes could be organized according to four general topics: counseling across sexuality, training, counselor characteristics, and experience.

In order to facilitate the development of categories and related components in accordance with qualitative research procedures, we initiated axial coding procedures to refine the organization of data into each category. This included the identification of relationships among the components within each category including subcategories and properties. We also identified dimensions among the concepts that made up the properties of each subcategory. A detailed presentation of each of the four categories and their related components are included in the results section.

The data analysis for the follow-up interviews utilized procedures similar to the initial interviews. Follow-up interviews produced no new themes but served to refine, clarify, and expand the definitions of existing concepts. In addition, the follow-up interviews appeared to explain participants' responses in terms of dimensional variations among categories, subcategories, and properties.

Results

As a result of analytic procedures, three tentative themes resulted from the data collection. The first theme, positive experiences in counseling, was present in all three data sources. Two out of the three study participants engaged in past counseling and other social services specifically for their domestic violence issues, with the third data source engaging in marriage counseling where the subject of past familial domestic violence was discussed. It is also important to note that all three participants reported feeling that the past social and counseling services were beneficial, even when the cycle of violence was not broken. All three study participants agreed that they would seek out services due to their positive past experiences.

One participant, "John", shared that he had seen several counselors throughout his life for a variety of reasons, including guilt, religious issues, and domestic violence. He spoke very positively about his most recent counselor, who he stated was very accepting of his sexuality and domestic violence issues. He stated, "He (the counselor) was a straight guy, but he was cool about it and treated us no differently than a straight couple."

Another participant, "Judy", shared that her counseling experiences

consisted of couples counseling only. She stated that during her couples counseling sessions, issues related to her extensive history of abuse and domestic violence surfaced. Judy felt that while she did not receive a lot of resolution to her abuse and domestic violence difficulties as a result of the counseling, she felt that it was more a function of being in couples counseling than the therapist. She clarified this point when she stated, "It (counseling) didn't help because I was in marriage counseling with... my husband at the time. He (husband) didn't want to acknowledge any of his problems or issues or anything like that. It was like a big waste of time." She added that she felt the counseling was a positive experience, even though resolution was not achieved. She supported this statement when she spoke about how counseling allowed her to see a pattern in her choice of partners and enabled her to become a more independent person.

The second significant theme was client responsibility. While all of the participants reported some positive experiences with counseling in the past, not all of their experiences were positive. John emphasized that, when counseling experiences are negative, it is the responsibility of the client to recognize the ill fit and to seek out counseling elsewhere. He stated, "If you go to someone and don't like them, try someone else." He went on to provide an example from his own search for a compatible counselor, 'I went to this one guy two or three times who had been recommended by some friends that had used him. It was horrible. It wasn't working...I'd end up getting more upset when I left then when I got there." He emphasized again that it is the client's responsibility to seek out a counselor that is "right" for him/her. He stated, "If this one isn't doing it for you try someone else...talk to some

people, try to get some referrals." He also emphasized that "You want somebody that's gonna be ok with you being gay...if they're not (comfortable with homosexuality) the last thing you need to do is to be going to them...that can cause bigger problems."

The third significant theme was negative experiences with the legal system. Two participants stated that they had contacted a social service agency, primarily police services, during their struggle with domestic violence. John stated that he had called the police on more than one occasion previously with mixed results. He verbalized the opinion that the quality of service he received from police services depended on which officer answered the call. He stated that some of the police officers in his area were gay-friendly, while some were not. John conceded that, overall, he had positive experiences with the police and that he was allowed to exit the crisis situations safely with their assistance.

The observation-based domestic violence victim, "Ray", stated that he had very negative experiences with social services, particularly the legal system and police services. Ray shared that during the domestic violence episode observed, he attempted to contact the police to gain assistance. He stated, "The police said they would come right away, but they never came. I had to move my stuff out with my friend threatening me the whole time." In addition, he shared that after the domestic violence episode, he contacted the magistrate to file a report. The magistrate would not agree to take the report as domestic violence. Legal services filed the report during attempted battery instead. This was found to be significant to the participant due to added social services and assistance that would have been provided if the case would have been considered domestic violence. He

stated, "I felt some rejected by the legal system around here. They didn't care that I was a victim since I wasn't straight." In addition, as a result of a lack of social service assistance for the participant, he later reported that he did not attend the court hearing out of fear of abuse by the defendant. As a result, all charges were dropped by the magistrate. He reasoned, "I just couldn't go. I was scared of what he (the abuser) might do to me. I just kept thinking of how straight women get all this assistance and I would be left to fend for myself. What's the use of going when the legal system around here doesn't care?"

Discussion

Using a queer theory paradigm, the primary focus of this study was to identify the perceptions of sexual minority domestic violence victims' experiences with counseling and other social services, along with their perceived likelihood of engaging in counseling or other social services in the future, if needed. In particular, the results will benefit the education of counselors and other social service professionals, causing them to be more mindful of their sexual minority clients' specific needs.

Implications

The results of this study have produced implications for several areas of counseling and counselor education. The two main implications for increasing competency with sexual minority intimate partner violence victims involves the training and experiences of counselors in both an academic program and in post-graduate practice. It is theorized that the knowledge and experiential activities that counseling students receive during their academic programs are vital to the development of their competency with sexual minority intimate partner violence victims. In addition, further

investigation into specific counselor characteristics that would be effective with the target population should be conducted. Another resulting implication that can be gleaned from the data is the improvement of continuing education programs and seminars. Based on participants' responses, significant additions need to be made to training to include topics related to sexual minorities and related intimate partner violence victims.

This study will contribute to the field in that it will add to the limited knowledge base of information on counseling attitudes and experiences of sexual minority individuals. While there is significant data on domestic violence within the heterosexual mainstream population, there is very little research on domestic violence in the sexual minority population. Also, there is virtually no research on the attitudes and experiences of sexual minority individuals towards counseling and other social services. The potential implications of this study on a large scale could improve the knowledge of the counseling and social services professions on their impact toward sexual minority populations. While generalizability is not the focus of this pilot study, the experiences and attitudes of future research participants can provide insight into the clients social service practitioners may find in their private practices or community mental health centers.

Limitations

This study provides insight into the lived experiences of the study participants and their experiences with counseling and other social services. However, limitations exist in this study due to the qualitative nature of the research (Lincoln & Guba, 1985). In general, qualitative research has limited generalizability. Specific limitations also exist and include issues related to

researcher's bias, participant selection, and the sample itself.

Researcher Bias

The first limitation of the study is the primary researcher himself. The primary researcher self-identifies as a white gay male counselor educator who has suffered multiple occurrences of intimate partner violence in his past. Since he is an active member of the target population, researcher bias is of concern. Therefore, the research team was vital in controlling for bias in all aspects of the study, including participant selection, observation and interview protocols, coding, and data analysis.

The primary researcher's membership in the target population can also be viewed as a strength, in that access to participants was easier. Sexuality-related barriers might have been lessened, as the primary research was able to relate to the research participants better, thereby lessening the possibility of feelings of stigma by the research participants.

Participant Selection and Sample

Selection of participants was limited to participants within geographic proximity to the researcher. Also, the sample size was small and may not be indicative of the larger population of intimate partner violence victims across the United States. While a large sample size is not required in qualitative research, the use of only ten study participants limits the generalizability of the study (Creswell, 1998). These factors can place limits on the transferability of the findings from this study.

Conclusion

The purpose of this study was to identify the perceptions of sexual minority domestic violence victims' experiences with counseling and other social services, along with their perceived likelihood of engaging in counseling or other social services in the future, if needed. Using a queer theory approach, this study allowed domestic violence victims to share their experiences with counseling and other social services. This study illuminated new ideas for preparing counselors to better attend to the unique needs of sexual minority intimate partner violence victims, particularly in relation to academic training and post-graduate continuing education. Based on the information that the participants provided, several ways for helping professionals to develop competency with sexual minority intimate partner violence victims are now suggested.

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Section II: First Place Winners of the 2013 LCA Conference Poster Session

Narrative Therapy Eating Disorder Group for Adolescent Females

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Current treatments for eating disorders leave much to be desired in both long and short term success rates. As such, there is a need for a more effective treatment, taking a new and creative approach to both the content and the process. This group, tailored for adolescent females with any of a variety of ED diagnoses, draws from narrative and art therapy, incorporating these to create a group with an emphasis on individual learning, growth, and self-discovery. Each group meeting combines psychosocial education, a specific activity, and group discussion to focus on a specific aspect of either eating disorder development or recovery and the ways in which members can learn from and utilize these different aspects of themselves in order to better facilitate their recovery. By combining these various approaches, members are able to learn and grow from both the group as well as from the insights of others.

Eating disorders are notoriously difficult to treat, and those treatments that are effective often do not produce results that can stand the test of time. For example, in a longitudinal study, Grilo et al. (2007) found that remission rates for bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS) were 74% and 83% respectively, but that relapse rates (of those in remission) reached 47% and 42% respectively. These rates are not out of the ordinary, with most transdiagnostic (additionally including anorexia nervosa; AN) studies finding relapse rates in the 35-50% range (McFarlane, Olmsted & Trottier, 2008; Keel, Dorer, Franko, Jackson & Herzog, 2005; Norring & Solhberg, 2003).

Eating disorders are often associated with intense amounts of shame, isolation, and low self-esteem (Keith & Simpson, 2009; Kaitsoff, Fehon & Grilo, 2009; Fitzpatrick, Lesser, Brandenburg & Lesser, 2011). These issues are exacerbated during adolescence, which tends to be the time of onset for these disorders. The group format encourages exploration of normal social interactions and the practicing of effective peer communication, which builds self-confidence, while also providing a safe and supportive environment in which to share thoughts and feelings that have previously been the source of significant guilt, embarrassment, and pain (Gallagher et al., 2013; Lazaro et al., 2011; Marmarosh, Holtz & Schottenbauer, 2005). The group therapy format can be highly effective in promoting feelings of acceptance by increasing self-esteem, which is critical during the period of adolescence (Corey & Corey, 2006; Mcgilley, 2006). Numerous studies have shown the group format to be effective for treating females with eating disorders (Choate,

2010; Crafti, 2002; Levine & Mishna, 2007; Weber, Davis, & McPhie, 2006).

Our proposed group is unique in that it is not a skill-focused group but rather is focused on personal expression and learning through creative and narrative outlets. Many group programs for eating disorders draw from cognitive behavior therapy (CBT) and focus on thought and action patterns. This group would take a more metaphorical approach to separating feelings/thoughts and actions and would allow members to learn new ways of viewing both themselves and the world around them. This approach might be better suited to the adolescent population because, in this stage of their life, critical identity formation is taking place. With several creative outlets, this group would give members the freedom to find things that work for them in their recovery and also to grow both individually as well as socially within the group.

For this group, we chose a narrative therapy approach with elements of art therapy. Narrative therapy was started by Michael White and later expounded upon by David Epston (Nichols & Schwartz, 2006). It was born out of the social constructionist perspective that personal experience is fundamentally ambiguous and that people will reject attempts at reframing their problems unless the new framing "fits" with their life's overall narrative. Through repetition, patterned life events come to form an individual's dominant narrative (Freedman & Combs, 1996). Over time this dominant narrative becomes internalized and forms the basis of an individual's identity (White & Epston, 1990). This leads to distress when the narratives are problem-saturated because then the individual's identity is based upon negative patterns and does not allow for flexibility or change (Payne, 2006; White, 2007).

Narrative therapy attempts to help clients focus on rewriting their entire story to support different possible interpretations of events, with an emphasis on creating a sense of meaningful cohesion to the elements. Having clients focus on addressing the story rather than a specific problem allows the client to externalize their problem, separating the issue from the person. Externalization allows the client to begin creating a more positive narrative (White, 2007). A major focus of narrative therapy is discovering and enhancing an individual's overlooked strengths (White & Epston, 1990). This reduces guilt, increases client empowerment, and encourages optimism.

The aim of narrative therapy is to teach clients to externalize their problems and learn to differentiate their problems from their identity. The goal is to "re-story" one's life experiences in order to form a comprehensible, cohesive narrative. This approach could be especially effective for eating disorders for two main reasons. The first reason is because eating disorders are essentially disorders of internalization. Eating disordered behaviors are compulsions used as coping mechanisms for issues such as perceived lack of control or compensation for loss (MacNeil, Esposito-Smythers, Mehlenbeck & Weismoore, 2012; Wagner & Much, 2010). Allowing for a more external view of the issue could provide clients with useable insight into the nature and source of their issues. Furthermore, sharing narratives can help reduce feelings of isolation and lead to an increased sense of universality (Yalom & Leszcz, 2005).

The second reason is that eating disorders often are very strongly tied to the client's identity, becoming a defining characteristic of their personality (Stanghellini, Castellini,

Brogna, Faravelli & Ricca, 2012; Ison & Kent, 2010). An important part of recovery and, often more importantly, relapse prevention, is understanding that an eating disorder is a set of behavior patterns, not a personality type. Narrative therapy can help clients to rediscover other aspects of themselves through the examination of their life stories and can help them view their disorders as distinct from themselves.

This group is unique in that it is not a skill-focused group but rather is focused on personal expression and learning through creative and narrative outlets. Many group programs for eating disorders draw from CBT and focus on thought and action patterns. This group takes a more metaphorical approach to separating feelings/thoughts and actions and allows members to learn new ways of viewing both themselves and the world around them in their own way and in their own time. This approach might be better suited to the adolescent population because, in this stage of their life, there is a lot of identity formation taking place. With several creative outlets, this group gives members the freedom to find things that work for them in their recovery and also to grow both individually as well as socially within the group.

Method

Participants

The population for this group is adolescent females (ages 14-17) with any diagnosis that falls under the category of eating disorders, including but not necessarily limited to: anorexia nervosa, bulimia nervosa, other specified eating disorder, and binge eating disorder. The decision not to limit the group to a single diagnosis was based on the finding that, generally, eating disorders are more similar than they are dissimilar, and that a more heterogeneous group can promote greater acceptance (Waller, 2008). Males were specifically excluded from this design because of the relative lack of research conducted with the population thus far and the fact that the effect of body image issues may differ too widely for males and females for the group to be maximally effective (Núñez-Navarro et al., 2012; Weltzin, Cornella-Carlson, Fitzpatrick, Kennington, Bean & Jefferies, 2012).

Procedure

This proposal is for a 12 week, semi-structured group. The group should ideally contain 10 to 12 members, in order to acquire enough diagnostic variety to ensure some representation from all "types" of eating disorders (e.g. bingeing, purging, restricting, over-exercising). The group will use a combination narrative therapy and art therapy approach, utilizing many selected arts and crafts type activities during sessions and an overarching writing assignment as ongoing homework between sessions. Each group session will last 90 minutes. Sessions will contain three major components: a check in that refers back to the previous week's topic, a psychoeducation component with accompanying handouts, and a hands-on creative activity to reinforce the message and encourage personal exploration and expression. Check-ins will always start off the sessions, with the psychoeducation portion immediately following. Discussion and activities occur after and constitute the bulk of each session. Between sessions, members will be asked to keep a running journal which will form the basis of their over-arching group project. These journal entries will be two separate narratives-the personal story of the member (their life, goals, etc.) and the story of their eating disorder.

The main goals of the group will be to enable members to see their own individual strength and worth, teaching members to find the positive and focus on the good, and encouraging members to separate their eating disorder from their identity. The group would also aim to encourage sharing as a means of both healing and interpersonal learning, with the goal of removing some of the shame and stigma often associated with eating disorders. Additionally, the group would strive to help members learn to think in a more present-focused manner rather than dwelling on the past.

Eating disorders are dangerous and pervasive issues with an early onset and few efficacious options for treatment. This group proposes a new perspective on treatment that specifically targets the population at the age of onset, with the goal of curbing the behavior and fostering adaptive coping skills at a crucial developmental period. This group could be used as an early intervention strategy or could be tailored to prevention instead. Although the research in which this proposed group is based shows promise, more research is still needed to reach maximum effectiveness for this population.

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Section III: Graduate Students' Articles

Disaster Displaced Readiness: A Proposed Model for Mental Health Care in a Post-disaster Environment

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Natural disasters such as the devastating Hurricanes Katrina and Rita in 2005 have resulted in higher rates of mental health problems including post-traumatic stress disorder, anxiety, depression, and the exacerbation of existing mental disorders (Schoenbaum et al., 2009). Mental health care services tend to be less effective in a post-disaster environment due to disorganization, poor communication, and a scarcity of professionals. This paper will formulate a model for providing mental health care services to a population of 15,000 in a proposed post-disaster environment. This includes screening and assessment procedures in addition to therapeutic and psychoeducational interventions. This will be referred to as the Disaster Displaced Readiness (DDR) Model. This proposal is a new approach to providing essential services to evacuees through an integrated community based approach that addresses housing, physical and mental health, and social concerns.
Key words: Disaster Readiness Model, Post-disaster, Hurricane Katrina, Mental Health Care, Crisis

According to Schoenbaum et al. (2009), approximately 1.5 million individuals from 117 counties/parishes in Louisiana, Mississippi, Alabama, and Texas were displaced from their homes following Hurricanes Katrina and Rita in 2005. This total includes approximately 372,000 school aged children who were subsequently evacuated and sent to schools in 46 states (Madrid & Grant, 2008). It has been well documented that large natural disasters can lead to post-traumatic stress disorder (PTSD), anxiety, depression, and the exacerbation of preexisting mental disorders across age groups (Schoenbaum et al., 2009). Katrina was no exception and its effects were compounded by the fact that a disproportionate amount of the affected population came from already underserved groups. Nearly 60% of the evacuees in Houston had annual incomes of less than $20,000 in 2004, and about a third reported making less than $10,000 in that year. Less than half of the Houston evacuees had health insurance, about a third had children with them, and a

disproportionate number (93%) of the evacuees were African American (Brodie, Weltzien, Altman, Blendon, & Benson, 2006). Nearly two-thirds of the respondents reported that their main source of health care came from the public hospital and clinic system rather than from a doctor's office.

During the crisis, hurricane victims often went without adequate medical care due to the destruction of medical records, inability to receive prescription medications, insufficient hospital beds, and a shortage of health care providers (Weisler, Barbee, & Townsend, 2006). One year after the hurricanes, New Orleans had a serious shortage of primary care physicians (140 of a previous 617) and psychiatrists (only 22 of a previous 196), forcing those in need to seek care in emergency rooms or clinics for any medical or mental health needs (Weisler et al., 2006).

Clearly, there is a need for improved mental health care for hurricane victims. Having experienced trauma, victims of natural disasters are more prone to mental health problems such as PTSD, depression, anxiety, anger problems, substance abuse, and sleep disturbances among others (Madrid & Grant, 2008). These conditions have also been linked to physical health problems such as hypertension, heart disease, and diabetes (Weisler et al., 2006). These numbers could be conservative as approximately 40% of the population impacted by Hurricane Katrina already had a chronic health condition (Weisler et al., 2006). According to a 2005 survey by the Center for Disease Control (CDC), up to half of the respondents indicated a possible need for mental health care services and a third demonstrated a need for mental health care with only 1.6% actually receiving services (Madrid & Grant, 2008). Parents reported up to half of the children in their care after the

disaster displayed behavior problems such as depression, anxiety, and problems sleeping (Weisler et al., 2006). These statistics highlight the disparity between the need for mental health care services and the availability of treatment in a post-disaster setting, which can be improved upon through planning and disaster readiness.

The Disaster Displaced Readiness Proposal

The Disaster Displaced Readiness proposal (DDR) involves the creation of a town in Louisiana that can accommodate 15,000 individuals from six counties and parishes in Texas and Louisiana that have been displaced due to a natural disaster, but would be unoccupied in a non-emergency state. The idea is that the individuals would have immediate access to housing, supplies, health care, and mental health care upon arrival at the DDR town. The six regions of interest are: Iberia, Cameron, and Vermillion Parishes in Louisiana and Chambers, Jefferson, and Orange Counties in Texas.

According to louisianaspeaks-parishplans.org, Iberia Parish housed 2,000 evacuees following Hurricanes Katrina and Rita, Cameron Parish had to evacuate 100% of its residents (9,861 people in 2005), and Vermillion Parish evacuated 16,000 individuals, 1,000 of which returned before the second storm and had to be rescued. The Hurricane Ike FEMA Impact Report (2008) indicated that Chambers County had a population of 28,771 in 2008, Jefferson County had the largest population of 241,975, and Orange County had 82,669 residents. The chief mental health concerns for the areas of interest included the need for more mental health care providers, case workers, treatment for PTSD, anxiety, and depression, care for the elderly, services

for the disabled, and care for non-English speaking residents.

There are obviously far more residents in these areas than the DDR town would be able to accommodate and considerations would need to be made concerning which evacuees would be granted a bed. Ideally, those who have family or friends elsewhere would permit another to take their place so that the space and resources could be used by those who need it most, but these concerns are beyond the scope of this article.

Mental Health Interventions

Schoenbaum et al. (2009) proposed a model of mental health care post Hurricanes Katrina and Rita that focused on the costs of treatment 7-30 months after the disasters occurred. This model will focus on the costs of screening and treatment for the first 12 months following the disaster. Each person would go through a screening process to detect the presence of common mental health problems. A self-report measure such as the Mental Health Inventory (MHI-5), K-6, or Patient Health Questionnaire (PHQ-9) (Schoenbaum et al., 2009) could be used as a screening measure. Those who screen positive for mental health issues will need further assessment and treatment by professionals, which will likely contain a mix of Master's level and Ph.D. level providers. If it is estimated that 7 months after the disaster, morbidity peaks at around 33%, with 26% having a mild/moderate condition and 6% having a severe condition (Schoenbaum et al., 2009), it is reasonable to assume that immediately following the disaster that mental health problems will be more prevalent. The findings from the 2005 CDC survey indicated up to half of respondents would possibly need mental health care services and approximately 33% clearly needing

services (Madrid & Grant, 2008), so we will assume that 50% of the persons who go through the screening process will need some form of assessment, and that 33% will need some form of therapy.

Screening

According to Schoenbaum's model, screening costs would be approximately $25 per unit whether the screening was done in person or over the phone. Following this model, screening 15,000 individuals would cost $375,000 and require a significant amount of time. Ideally, the screening questionnaire could be administered electronically in groups of 30-40 to both expedite the process and cut costs. Screening sessions should be supervised by a mental health professional that is qualified to administer screening measures although trained volunteers could serve as assistants answering questions as needed and providing accommodations for the disabled and those unable to read or write.

In the event that computers are not available, the screening questionnaire could be distributed in a paper and pencil format and scored by volunteers. This method would be more costly due to the printing materials and the additional time required to complete the screening process. The use of a short questionnaire would minimize the time and monetary costs of this testing method. Volunteers will undergo training emphasizing ethical considerations in accordance with the American Counseling Association's 2014 Code of Ethics including section A.2. regarding informed consent, section B regarding confidentiality, and section E regarding assessment, evaluation, and interpretation. Following ethical training, volunteers will also receive training in screening procedures and would need to be available to score the screening instruments quickly and accurately.

Qualified mental health professionals should be available to supervise and perform reliability checks in order to ensure accuracy.

Assessment

Following the data from the 2005 CDC survey, approximately 50% of the individuals who go through the screening process will possibly show some indication that they may need further services. These individuals will need to proceed to the assessment stage (Madrid & Grant, 2008). According to Schoenbaum et al. (2009), a one-on-one clinical assessment would run between $75 and $100 per unit. After running 7,500 clinical assessments, the monetary cost would be between $562,500 and $750,000. At 30 minutes per assessment, it would take a total of 3,750 hours to complete 7,500 assessments. The monetary and time requirements for official clinical assessments are not feasible or efficient for this post-disaster setting.

A quicker and more cost efficient way to implement the assessment process would be to utilize an informal assessment as an extension of the screening process. Essentially, a longer and more detailed self-report survey, administered in the same way that the initial screening measures were, would take the place of a formal clinical assessment. These informal assessment measures would include scales for more serious disorders such as acute stress disorder, post-traumatic stress disorder, depression, and anxiety. A reliable and valid assessment measure would allow the respondents to demonstrate the severity of their symptoms and the areas of interest.

Similar to the screening procedures, administering the assessment questionnaire electronically in large groups would be the most efficient and cost effective approach. An electronic form would allow for computerized scoring, saving time and human resources. In the event that computers are not available, the survey could be administered by hand in a paper and pencil format for the cost of printing the materials and providing sufficient supervision. The actual assessment process should be supervised by a qualified mental health professional with the assistance of proctors who are available to help answer questions and assist those with developmental disabilities or those unable to read and write as needed. The main drawback to the paper and pencil assessment format is similar to the one for the screening process. While the electronic assessment could be scored by a computer, a pen and pencil assessment will need to be scored by hand, requiring more time and human resources. A group of raters should be trained to quickly and accurately score the assessments and determine where the problem areas lie, and the severity of the presenting issues (mild, moderate, or severe). Reliability checks should be performed randomly by qualified professionals in order to ensure accuracy. These raters should also have basic training regarding ethical considerations including informed consent and confidentiality (ACA, 2014, sections A.2., B, and E).

Treatment

Up to 33% of the individuals that go through the screening process could show a clear need for more extensive treatment. In this particular town, therapeutic resources would need to be available for a potential 5,000 individuals. According to Schoenbaum et al. (2009) a Master's degree-level provider would cost approximately $90 for an individual session or $210 for a group session. A Ph.D.-level provider would cost approximately $135 for an individual session and $245 for a group session; however, rates may vary by location. All mental health services should be provided by licensed

professionals with sufficient training in ethical considerations.

Due to the cost and the large numbers of people in need of treatment, the use of groups would be the most cost effective and efficient way in which to provide therapy. Individual services should be available, but limited to the most severe cases in which group therapy is not effective. Smaller psychotherapeutic groups of 7-10 should be reserved for the severe conditions, while larger psychotherapeutic groups of 12-15 could be utilized for mild to moderate cases. In order to provide effective treatment for the largest amount of people, psychotherapeutic groups should be available at multiple times for one to two hours. Closed groups would help to ensure continuity of care and confidentiality. The groups could meet once a week for 8-10 weeks and focus on cognitive-behavioral or solution-focused techniques that are both efficient and effective (Schoenbaum et al., 2009). Due to the grief and loss that many displaced individuals will likely be experiencing, it may also be beneficial to have small process or grief groups in which the evacuees can share their experiences and bolster their strengths by expressing their grief and learning coping skills.

Large psychoeducational groups, limited by space and seating availability, following a more didactic format could be provided for all in need of therapeutic services. These groups would be focused on educating the attendees about coping methods, psychological first aid, and where to find resources should they be in need of more comprehensive or emergency care. Psychoeducational groups could be offered on a fairly regular basis, such as weekly or biweekly, and would be simple to implement at a low cost in the forms of presentations, lectures, and question and answer sessions. A space large enough to accommodate a large number of attendees such as a school auditorium would be helpful to implement this treatment aspect.

A small proportion of those in need of mental health care services may require hospitalization for extremely severe cases in which the patient has a high risk of harming self or others. Those who are hospitalized would require continuous supervision by nurses and staff. Medications would ideally be managed by a psychiatrist, but in the event that one is not available a medical doctor or nurse practitioner could manage pharmacotherapy. It is essential to manage pharmacotherapy because many evacuees may have received psychiatric care before displacement but may not have their medications with them. Considerations should also be made for methadone clinic patients, as success in the program is much more likely when the patients are able to participate on a regular basis for at least a year (Reisinger et al., 2009). Inpatients would likely attend a variety of therapeutic group sessions with occasional one-on-one therapy sessions. According to Schoenbaum et al. (2009) inpatient hospitalizations would cost about $900 per unit, per night. Due to the high cost of this intervention, it should be reserved only for the most severe cases which require continuous supervision.

In the event that computer and internet access are available to the displaced population, a web-based treatment approach in accordance with the current ACA Code of Ethics (ACA, 2014, section H) could be provided for those with mild to moderate mental health care needs. This treatment would be cost effective in that relevant treatment modules could be made available following the screening and assessment procedures. There are some

limitations to a web-based intervention approach. A study investigating the rates and motivations for non-use and dropout attrition in web-based interventions designed for natural disaster victims indicated that there tend to be high rates of non-use attrition at about 48%, that approximately 30% of those that completed the screening assessment did not access the treatment modules, and that 9% of the control group and 20% of the intervention group that accessed a treatment module did not complete the content (Price, Gros, D. F., McCauley, Gros, K. S., & Ruggiero, 2012). The most common reason for not accessing or completing the treatment modules was that the participants did not feel that the material was relevant to their situation. Those that did complete the treatment modules tended to have received mental health care services prior to the intervention (Price et al., 2012). In light of these findings, a web-based intervention should be considered as a supplemental approach to treatment or reserved for those who either present with a low-risk for mental health problems or are functioning well but would like access to educational materials.

Mental Health Care Providers

Providing adequate mental health care services for 15,000 individuals will require a sufficient amount of mental health care providers. Personnel will be needed for screening, assessment, treatment, medication management, and supervision. A mix of doctoral and masters level professionals with knowledge in the areas of screening, assessment, individual and group counseling, career, school, and clinical counseling backgrounds will need to develop an integrative team approach in order to provide the best level of care in the post-disaster environment. Interdisciplinary teams, including psychiatrists, psychologists, counselors, nurses, doctors, emergency responders, and school professionals, will help to ensure continuity of care in order to care for the evacuees effectively and efficiently. Multicultural competence is essential as the disaster ready town will house people from a variety of different regional areas, not to mention ethnic backgrounds, religious backgrounds, and socioeconomic backgrounds. There may be some language barriers, and so it would be useful to have bilingual professionals available in order to lessen these stressors. There will be a need for professionals that can work with a variety of age groups as well as this town will be serving adults, children, adolescents, and elders.

Most likely, trained volunteers and assistants will be able to aid in the administration and scoring of the screening and assessment questionnaires. In some cases, volunteers and assistants, especially those in graduate training programs, may be able to facilitate group therapy sessions and peer support groups under the proper supervision. The use of volunteers and assistants will cut some of the costs associated with hiring so many mental health professionals and aid in the distribution of mental health care services.

In order to meet the counseling needs of this population, a number of full-time mental health professionals will need to be hired including: 10-15 masters-level practitioners, 7-10 doctoral-level practitioners, and up to 3 psychiatrists. In the event that an insufficient number of psychiatrists are available to manage psychotherapeutic medications, those in need of medication could be referred to the general medical staff. Trained volunteers and assistants, as available, will supplement this staff and be able to manage administrative duties such as scheduling and assembling therapeutic

groups. Some mental health professionals or students in graduate training programs may also be available to provide a limited number of one-on-one counseling sessions pro bono for those with severe needs.

Implications for Counselors

There are a number of things that counselors considering providing mental health care services to disaster displaced individuals need to take into account. One of the foremost issues is that counselors need to be aware of their own prejudices and biases before working with this population. Since the 15,000 people completing the screening process and the 5,000 that may ultimately receive treatment will be coming from six different counties and parishes from Texas and Louisiana, there will undoubtedly be multicultural issues. Those receiving services will likely come from a variety of ethnic, religious, and socioeconomic backgrounds and will be in various stages of development. Psychotherapeutic groups should be formed and conducted keeping these factors in mind.

As previously mentioned, a disproportionate number of those displaced by Hurricanes Katrina and Rita were African American. Unfortunately, discrimination and systemic oppression are still very real factors in New Orleans, and many other major U.S. cities, as many of the social strata are defined not only by income or residential area, but by skin color. Many mental health problems that are related to systemic oppression including PTSD and depression can be exacerbated in the post-disaster context. Consequently, mental health professionals need to maintain multicultural awareness and provide services while focusing on clients' strengths and existing coping skills, including close familial and community relationships, spirituality, and cultural

identity, in addition to fostering new ones (Goodman & West-Olatunji, 2009). Many clients, especially those from the New Orleans area, may also have sources of transgenerational trauma or resilience from past disasters, such as Hurricane Betsy, that counselors may be able to utilize when evaluating client risk and protective factors and implementing treatment (Goodman & West-Olatunji, 2008).

Mental health professionals may find themselves working with first-responders, which is a pertinent example of multicultural differences. First responders tend to be highly influenced by their organizational culture and by the nature of their occupations, but are not immune to the stressors of their duties and so may require mental health interventions. First responders tend to fall into two groups: the "high-risk rescuers" who are at higher risk due to terrorist activities and the "rescuer-victim" who occupy both roles simultaneously. Counselors will most likely encounter the rescuer-victim responders in the post-natural disaster context. First responders tend to put the needs of others ahead of their own and may be reluctant to seek mental health treatment due to their occupational culture that may consider seeking services to be a sign of weakness, however there is also a high incidence of PTSD and substance abuse amongst this population. Effective treatment interventions for first-responders tend to focus on peer-support and psychoeducational groups (Castellano & Plionis, 2006).

Counselors will also likely encounter a need for career counseling services since many, if not all, of the evacuees will have been displaced from their jobs as well as their homes. Many may not have a job to go back to or may need to consider starting over in a new area. Counselors working with this

population should be competent in career counseling.

Due to the large number of persons that will be in need of mental health care services, counselors need to focus their treatment approaches on brief techniques from a solution-focused perspective. An emphasis on teaching effective coping tools that can be used outside of the therapeutic environment should expedite the healing process and allow the counselors to provide services to the largest amount of people in a timely manner. There is a large amount of empirical support for the effectiveness of cognitive-behavior therapies in a post-disaster context (Schoenbaum et al., 2009).

Due to the nature of treating disaster displaced individuals, there is a potential for counselors to experience a level of vicarious traumatization. In some cases, mental health providers may be victims themselves and have experiences akin to the first responder rescuer-victims. Counselors and other mental health providers need to maintain good self-awareness and ensure that they are meeting their own needs so that they can continue to provide the best care for their clients. The availability of other professionals should facilitate consultation practices and a possible avenue of support for mental health professionals could be the formation of peer-support groups. It may also be wise to include a back-up staff, or a rotating staff of mental health professionals with periods of mandatory leave in order prevent or ameliorate the effects of burnout. In addition to a back-up staff of mental health professionals, it may also be prudent to maintain a roster of volunteers that are able to provide mental health or medical services in the event of a disaster, legal advisors, office workers, and anyone else that may be able to provide services during a disaster. All volunteers and mental health care

professionals that agree to volunteer their services should also be thoroughly trained in providing disaster relief services.

Conclusion

Natural disasters are unavoidable and costly both in terms of human lives and resources. Response time tends to be slow and inadequate due to disorganization, miscommunications, and the dissolution of social services that often occurs in a post-disaster context (Brodie et al., 2006; Springgate et al., 2011). Disaster displaced readiness plans such as this one may help to facilitate quicker response times by mitigating some of these limitations. A community based participatory research (CBPR) approach in which community members, policy makers, mental health, and medical professionals work together to create a framework for meeting post-disaster needs is essential for the most effective implementation of care in this setting (Springgate et al., 2011).

Early intervention and the availability of mental health care services will ideally mitigate future ill effects that often plague natural disaster survivors. The costs of implementing these services will be great, but less than future costs to provide services for unmet needs. The formal costs of implementing this model are outside of the scope of this report. The figures have been extrapolated from previous studies and may vary by region.

Disaster readiness is a matter of social interest. Slow response times and the lack of mental health care services in past disasters have resulted in unmitigated human suffering and a higher prevalence of mental disorders that puts more strain on an already overburdened system. There is a large disparity between the need for and the availability of mental health care services even in times where there is no

disaster and this is only exacerbated in a post-disaster context. Efforts to meet the needs of disaster victims may help to close this gap and prevent much human suffering.

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Test Questions for Licensed Professional Counselors

A score of 100% is needed on the following items. You need to submit this test along with the request for a certificate to receive hours. Once scored, you will receive a certificate verifying **2.5 CLOCK HOURS** of CEUs.

CE/CEU Questions for Supporting Mandated Child Abuse and Neglect Reporters:

1. Most states have four commonly identified types of recognized child abuse. They include physical abuse, sexual abuse, emotional abuse, and _____?
   a. Academic abuse
   b. Psychological abuse
   c. Verbal abuse
   d. Neglect

2. Is this statement true or false?
   "In general there is one accepted way to report child abuse in the United States."
   a. True
   b. False

CE/CEU Questions for the Sexual Minority Domestic Violence Victims' Article:

3. Research suggests that the general public reports feeling more strongly about a battered homosexual partner leaving his or her partner than a battered heterosexual partner because:
   a. Abuse is not seen as substantial enough
   b. Religious beliefs
   c. Perceived permanency of the relationship
   d. Both A and C
   e. Both B and C

4. The results of the Sexual Minority Domestic Violence Victims Pilot Study discovered 3 themes:
   a. Negative experience in counseling, lack of client responsibility, positive experience with legal system
   b. Positive experience in counseling, client responsibility, and negative experience with legal system
   c. Negative experience in counseling, client responsibility, negative experiences with legal system
   d. Positive experience in counseling, lack of client responsibility, negative experience with legal system

CE/CEU Questions for the Narrative Therapy Eating Disorder Group for Adolescent Females

5. Narrative therapy has clients _____ their problems.
   a. Forget
   b. Externalize
   c. Talk about
   d. Internalize

6. Eating disorders are essentially _____ disorders, and often serve as a _____.
    a. Internalized, coping mechanism
    b. Externalized, way to receive attention
    c. Internalized, way of expression
    d. Externalized, coping mechanism

CE/CEU Questions for the Disaster Displaced Readiness Article:

7. Is this statement true or false?
   "The Disaster Displaced Readiness proposal (DDR) involves the creation of a town in Louisiana in which people from Texas and Louisiana who are displaced due to a natural disaster can occupy."
    a. True
    b. False

8. When it comes to counseling considerations when working with disaster displaced individuals it is imperative that counselors are aware of _____, and are competent in multicultural differences.
    a. Burnout
    b. Personal limitations
    c. Countertransference
    d. Personal prejudices

The Louisiana Counseling Association is an NBCC-Approved Continuing Education Provider (ACEP) and may offer NBCC-approved clock hours for programs that meet NBCC requirements. Programs for which NBCC-approved clock hours will be awarded are identified in this Journal. The ACEP is solely responsible for all aspects of the Journal.

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The Louisiana Counseling Association awards **2.5 CLOCK HOURS** of continuing education for reading the *Louisiana Journal of Counseling (LJC)* and correctly completing the Study Questions. To receive a certificate verifying your participation in this easy and inexpensive way to earn valuable CEU's, complete the form below and mail it, **along with $10 and your completed test questions**, to the following address:

Diane Austin
LCA Executive Director
353 Leo Street
Shreveport, LA 71105

I verify that I have read the entire **FALL 2014** edition of the *Louisiana Journal of Counseling (LJC)* and am now applying for **2.5 clock hours** of continuing education credit in conjunction with correctly answering the Study Questions for this year's journal.

Name (PRINT – as you wish to have it appear on your certificate):

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City   State   Zip

Phone __(cell)_____(other)_____

E-mail_____

Signature_____

Date_____

*Make checks payable to **LCA**
A Verification form with your clock hours will be mailed directly to the address provided on this form.

GUIDELINES FOR AUTHORS

The *Louisiana Journal of Counseling (LJC)* publishes articles that have broad interest for a readership composed mostly of counselors and other mental health professionals who work in private practice, schools, colleges, community agencies, hospitals, and government. This journal is an appropriate outlet for articles that (a) critically integrate published research, (b) examine current professional and scientific issues, (c) report research that has particular relevance to professional counselor, (d) report new techniques or innovative programs and practices, and (e) examine LCA as an organization.

MANUSCRIPT CATEGORIES

Manuscripts must be scholarly, based on existing literature, and include implications for practice. The following categories describe the nature of submitted manuscripts. However, manuscripts that do not fall into one of these categories may also be appropriate for publication. These categories were adapted from the American Counseling Association's *Journal of Counseling and Development (JCD)*.

1. **Conceptual pieces.** New theoretical perspectives may be presented concerning a particular counseling issue, or existing bodies of knowledge may be integrated in innovative ways.
2. **Research studies.** Both quantitative and qualitative studies are published in *LJC*. The review of the literature should provide the context and need for the study, followed by the purpose for the study and the research questions. The methodology should include a full description of the participants, variables, and instruments used to measure them, data analyses, and results. The discussion section includes conclusions and implications for future research and counseling practice.
3. **Practice articles.** Innovative counseling approaches, counseling programs, ethical issues, and training and supervision practices may be presented. Manuscripts must be grounded in counseling or educational theory and empirical knowledge.
4. **Assessment and Diagnosis.** Focus is given to broad assessment and diagnosis issues that impact counselors.

MANUSCRIPT REQUIREMENTS

All manuscripts must adhere to the guidelines set forth in the *Publication Manual of the American Psychological Association (6th ed.).* The APA *Publication Manual* sets forth all guidelines concerning manuscript format, abstract, citations and references, tables and figures, graphs, illustrations, and drawings. Special attention should be given to the guidelines regarding the use of nondiscriminatory language when referring to gender, sexual orientations, racial and ethnic identity, disabilities, and age. Also, the terms "counselor" and "counseling" are preferred to "therapist" and "therapy."

1. Submit an emailed, electronic, blind copy in Word of the entire manuscript to Meredith Nelson, mnelson@lsus.edu, Psychology Dept., One University Place, Shreveport, LA 71115 or three (3) clean, hard copies of the entire manuscript with an electronic version to Peter Emerson, *LJC* Editor, pemerson@selu.edu, SLU Box 10863, Hammond, LA, 70402.
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