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Kellie Camelford, Erin Dugan, & Krystal Vaughn
Co-Editors

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The **Louisiana Journal of Counseling (LJC)** is the official journal of the Louisiana Counseling Association (LCA). The purpose of LCA is to foster counseling and development services to elementary, high school, college, and adult populations. Through this united focus, LCA maintains and improves professional standards, promotes professional development, keeps abreast of current legislation, and encourages communication among members.

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From *the* Editors

Moving Forward in Challenging Times

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It is with our sincere pleasure to welcome the role as the Fall 2020 co-editors for the Louisiana Counseling Association (LCA) journal succeeding Drs. Meredith Nelson and Peter Emerson, our colleagues and friends. With a collective experience of over 23 years, Dr. Krystal Vaughn, Dr. Kellie Camelford, and Dr. Erin Dugan are proud to have been selected as the next co-editors for LCA. Drs. Vaughn, Camelford, and Dugan have had the fortunate experience to serve as editors with various publishing companies and association over the past years including, IGI Global, Routledge, the American Psychological Association, the American Counseling Association, the American Child and Adolescent Counseling Association, the Association of Counselor Education and Supervision, the Association for Specialists in Group Work, the Association for Play Therapy, the National Board of Certified Counselors, the Louisiana Counseling Association, and the Louisiana Trust Fund. As Dr. Nelson mentioned in her editorial address in the Fall 2019 journal, "LCA is one of the leading counseling organizations in the country." As co-editors, we will continue to publish high quality manuscripts as well as continue to strengthen the quality of research published in the journal.

Although COVID-19's impact on our country, state, and community has been devastating, LCA has continued to support its members. In the Fall 2020, the call for manuscripts continued to go out to its members and researchers across the world.

Again, we are honored to serve as LCA Journal's co-editors. Thank you for such a wonderful and meaningful opportunity

~ Kellie Camelford, Erin Dugan, & Krystal Vaughn

Co-Editors

Incorporating the Reproductive Story Intervention for Men Having Experienced Pregnancy Loss

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Pregnancy loss and the disenfranchised grief that can accompany the loss can be difficult for parents to process. Counselors can struggle when counseling clients to find a way to process their pregnancy loss and grief. Jaffe (2017) described the reproductive story as an intervention for therapists to use when working with clients who experience a pregnancy loss. Therapists can use a reproductive story to examine clients' developmental aspects of their childhood and the narrative they developed about what a parent is and what a family look likes. The grief of men will be explored, examining how the reproductive story can be universally applied through different theories to help clients cope with the grief experienced.

Keywords: pregnancy loss, miscarriage, stillbirth, men, grief

According to the American College of Obstetrician and Gynecologists' (2015) research, miscarriage is a common occurrence, stating that approximately 10% of all clinically recognized pregnancies end in a miscarriage**.** Pregnancy loss is not what people envision when trying to start or expand their family, but it can be devastating for those who it becomes reality. This experience comes with a complex grief process, that is different from others in that the person is left to grieve what could have been instead of memories of what was lost. Pregnancy loss is a grief of the future, not the past. When someone loses a friend or loved one, they have memories of them, pictures or potentially other items that hold sentimental value, when someone experiences pregnancy loss those memories are never made, and the grief is focused on what could have been. Counselors working with this population have to be prepared to explore their own reproductive story and the impact it will have on the therapeutic relationship (Jaffe, 2017). Counselors will practice with those who have experienced pregnancy loss due to their own experiences with loss (Marrero, 2013). Particularly, counselors will need to know how to navigate what and when to address their reproductive story with their clients. Utilizing research on pregnancy loss will help counselors learn ad prepare for working with this population's grief and trauma (Jaffe, 2016, 2017).

In 2017, the American Psychological Association dedicated a special research section on psychotherapy for pregnancy loss. Markin (2017) stated the research was meant to address recommendations for counselors, clinical and psychological aspects, societal concerns, and areas for future research. Researchers examined and discussed the disenfranchised grief experienced by parents throughout the section. Doka's (1989) research originated the term, disenfranchised grief, that most accurately describes parents' grief from pregnancy loss. Doka's disenfranchised grief described an experience of loss that is not openly acknowledged, publicly mourned, or socially supported. Society is often dismissive of a parent's grief from a pregnancy loss by not recognizing the significance or depth of the pain associated with the loss, especially in comparison to other losses (Lang et al, 2011).

With 10% of all clinically recognized pregnancies ending in miscarriage, most of us have either experienced a pregnancy loss or know someone that has experienced a pregnancy loss (American College of

Obstetricians & Gynecologists, 2018). This manuscript seeks to add to the literature on pregnancy loss, by helping counselors recognize the versatility in Jaffe's (2017) reproductive story through different theoretical approaches and how it can be utilized with male clients. Jaffe's (2017) reproductive story is the concept that every person has a reproductive story and the story is used to help them frame the trauma when the story has gone in a way they did not expect, like a pregnancy loss.

Counselors can use the reproductive story intervention to help parent's process their grief. Jaffe and Diamond (2011) stated that all people have a reproductive story and their story starts in early childhood. Many factors shape their story, including their own parents, how they were parented, and their desire to have or not have kids. The grief parents' experience can come from a lack of control they feel when their reproductive story takes a turn they did not plan (Jaffe, 2017). The goal of this intervention is to help clients connect with the child they lost, take ownership of their own reproductive story, and to process the grief associated with the loss of the pregnancy.

Literature Review

Kersting and Wagner (2012) conducted a review of the thorough review of the literature and found that men are affected by pregnancy loss but stated there is a limited amount of research in this filed. In one of the few more recent studies, there was a link between grief and depression in men and the gestational age at the time of loss (Riggs et al., 2018). Research conducted by Koert et al. (2019) found that men were adversely impacted by pregnancy loss. In this study, men expressed a desire to be included and acknowledged by healthcare professionals and further resources to assist with support, information or treatment. Research has been done on some approaches as to how counselors should handle clients who have experienced pregnancy loss. Thus, we plan to explore a couple of these approaches and how they can utilize the reproductive story.

Approaches to Pregnancy Loss

When a pregnancy is lost, parents can feel this on deeper levels, feeling that their world has been shaken as the crumbling of their reproductive story is happening around them (Jaffe, 2017). Jaffee developed the reproductive story to assist clients in processing their pregnancy loss. The reproductive story is an intervention that can be integrated within a variety of theories, due to how universal the reproductive story is. Counselors look to different theories and approaches to find the most appropriate ways to help their clients process the loss of their reproductive story. Attachment Theory and Cognitive-Behavioral Therapy were chosen as two examples to show how one can incorporate the reproductive story into theory due to them being used in the treatment of those who have experienced pregnancy loss.

Attachment Theory. Treating pregnancy loss can become complicated when clients are attempting to continue their reproductive story and have another child (Hutti et al., 2013). Emotional distress has been associated with a pregnancy after a previous pregnancy loss (Shreffler et al., 2011). O'Leary (2004) suggests reframing unresolved grief through an attachment model. It is argued that forming an attachment to a new child can be compromised if parents are still struggling with their role with the deceased child. The research states that a new level of grief forms when they are expecting a new baby after pregnancy loss, which can lead to enduring grief if left unacknowledged. Warland et al. (2011) study found that pregnancy and infant loss has long term effects on parents, with participants from their study maintaining a level of detachment with their child into childhood. Warland et al. suggested that the attachment was disrupted by the grief of the loss and bonding with their

subsequent child, with the potential for long-term impacts on parenting the child. O'Leary and Henke (2017) researched the support parents need with helping to form an attachment with a new baby after a pregnancy loss. They found that helping clients bond using attachment theory in individual and group settings supported the relationship with the baby lost during the former pregnancy, while continuing the bond with the current pregnancy. Jaffe (2017) explored how the reproductive story helps facilitate the grieving process. Utilizing the reproductive story intervention could help clients develop a healthier bond and attachment by processing how their reproductive story has not gone as they expected.

Cognitive-Behavioral Therapy. The use of cognitive-behavioral therapy (CBT) in treating pregnancy loss can be very useful (Bennett et al., 2012; Wenzel, 2017). Aspects of CBT like cognitive reframing, journaling, relaxation/mindful activities, and role playing to name a few can be beneficial to clients who have experienced pregnancy loss. Bennett et al. (2012) researched the use of CBT on behavioral and psychological effects on women who experienced grief following a pregnancy loss. Utilizing certain CBT techniques such as emotion regulation, skill building, and exposure, this research saw a decline in reported grief symptoms. While this was a small study, it provided evidence in support of using CBT in working with women who have experienced pregnancy loss. In a later study conducted by Wenzel (2017), they stated that pregnancy loss is accompanied by an intense meaning that interferes with the belief system of those who experienced the loss, and that it can be difficult for them to manage with previous skills. Wenzel argued that CBT has the possibility of being one of the more effective approaches as it targets emotion, behavior, and cognition within the therapeutic relationship. She then asserted that the amount of empirical studies and CBT's approach disrupts negative meanings and beliefs. Wenzel emphasized that these three aspects of CBT were most effective: cognitive restructuring, behavioral activation, and mindfulness and acceptance. An example of this was how cognitive restructuring can help clients address the feelings of guilt or blame they have associated with the loss. Wenzel stated that the balance between those three aspects and the therapeutic relationship targeted the symptoms of grief following a pregnancy loss.

Utilizing CBT, a counselor could help their client process the client's reproductive story, but also assist them in challenging negative thoughts about themselves, using mindfulness and acceptance to focus on the present and accept the next part of their reproductive story. The combination of the reproductive story and CBT could be especially useful in helping men process their pregnancy loss. By helping men to recognize their reproductive story, they can then utilize CBT techniques to assist with client's potential thoughts of shame or guilt and help them to be in the present.

Pregnancy Loss and Men

Pregnancy loss takes many forms, each coming with its own complex grief process. Bonnette and Broom (2012) found that research around stillbirth focused almost exclusively on the experience of women and very little was reported on the experiences of men who experienced pregnancy loss. Typically, pregnancy loss is seen more as a women's issue (McCreight, 2004: Murphy, 1998; Riggs et al., 2018; Rineheart & Kiselica, 2010). Men's perspective on pregnancy loss is an area often under researched or reviewed in literature. Parents often experience enduring grief and emotional distress after a pregnancy loss, but research and guidelines focus on women's care. Current literature does not thoroughly address the complex nature of men's grief (Obst et al. 2019).

The mental health of men who experienced pregnancy loss is an area of concern as they share similar feelings associated with disenfranchised grief as

women (Scheidt et al., 2012). Rinehart and Kiselica (2010) stated that if men have the expectation of shouldering the emotions of their partner, their own emotional wellbeing should be just as important to clinicians. Rinehart and Kiselica examined a case study looking at a 24-year old man, whose girlfriend experienced a miscarriage while he was in prison. This client was seen by the second author, referred to as Dr. K, in which she raised three points of concern when treating him. These points were that he struggled with the pregnancy loss because it was real to him, he had common beliefs about masculinity, and he was incarcerated, placing him in an environment that is far less accepting of emotions. Society still holds the belief that men should be strong, failing to create opportunities that allow men to express themselves in a beneficial way (McCreight, 2004).

Bonnette and Broom (2012) conducted a qualitative study and interviewed 12 men to share their stories of pregnancy loss. They explored the experience of fathers and how they engaged with their unborn and stillborn children and the perception of their grief. Bonnette and Broom (2012) found that ultrasounds help in establishing the father role and bond with the child. Furthermore, they found that the concept of identities, such as being labeled a father, played a large role in the grief process. The participants in this study affirmed that by honoring the lost child helped affirm their identity as a father and the recognition of this identity supported them through their grief, while a lack of recognition only made it harder to grief and display that identity.

Altogether, Attachment theory and Cognitive-Behavioral Therapy are just two approaches that have been used in helping those who have experienced pregnancy loss. While men's experiences still need to be explored more in the research, they do experience pain associated with that loss (Riggs et al., 2018). Jaffe (2017) states that every person has a reproductive story. Counselors learning about the reproductive story and how it could be utilized with male clients, through the counselor's theory of choice, could serve to benefit this unresearched population. Next is a scenario to help explore a male's experience with pregnancy loss to help in conceptualizing the integration of the reproductive story.

Scenario

Michael is a 27-year-old biracial male. He was in his second year of graduate school when his wife experienced a miscarriage at 8 weeks. This was the second pregnancy they have lost, the first occurring when he was dating his wife when she was 19 and he was 21 years old. Michael stated that they did not tell anyone outside of a select few friends about the first loss. He explained how they were afraid of the reaction of family and peers. He shared that their immediate family knew about the second loss and were supportive to his wife but did not know what to say him other than simple condolences. Michael has struggled to talk to his wife about his feelings over the miscarriages, as he feels that he needs to be there for her since she is the one that physically experienced the loss in addition to being emotionally supportive. Michael's wife expressed to him that she feels alone in her grief, as he has not expressed anything to her other than support. Michael stated that he has always wanted a family, as he comes from a very large family. He was excited when he found out his wife was pregnant, as he felt they were in a better place for a child. Michael and his wife eagerly began to plan for their growing family, and he was devastated when the doctor told them about the miscarriage. Michael shared that he does not talk about the first loss and has struggled to express fears over not having a family. It has been approximately nine months since the loss, and Michael does not feel he can discuss his grief as anytime it is mentioned with friends or family, the conversation comes to a stop with an awkward silence. He recently

found out that his wife is four weeks pregnant and stated that he is experiencing a range of emotions, from excitement to fear. Michael stated he wants to find a way to discuss the loss he has experienced while finding a way to have hope that he will have the family he always wanted.

Conceptualization of the Idea

In the scenario, Michael shared similar feelings and experiences to other men who have experienced pregnancy loss. Michael's counselor can incorporate the reproductive story intervention to help Michael process his grief and his feelings about the pregnancy losses he has experienced. There are several aspects of Michael's grief that align with the case study done by Rinheart and Kiselica (2010). Michael felt that the pregnancies were real to him, as he looked forward to becoming a father and shared the belief that he should be strong for his wife through their losses. Michael also felt unable to discuss the losses they experienced due to stigma surrounding the first pregnancy occurring at a younger age and the lack of space created for him to grieve his loss. Michael admitted that his wife was open to discussing the miscarriages, but he felt he needed to be strong for her as society has instilled the notion that pregnancy loss is a woman's issue. Michael is struggling to express the grief he has experienced, because he doesn't feel he has the space or opportunity that allows him to express it (McCreight, 2004).

He is possibly experiencing prolonged or pathological grief due to the unresolved emotional distress from the previous losses experienced, complicated by the new bond he is trying to develop with his wife's current pregnancy (Shreffler et al., 2011). Michael's reproductive story has taken a turn he did not expect and has shaken the concept of what he hoped his family would be. Through attachment theory, helping Michael process this aspect of his reproductive story and processing the attachment he had to the child he lost. Processing the attachment and grief associated with the pregnancy loss could help prevent intergenerational traumas (Diamond & Diamond, 2017). Wenzel (2017) identified three aspects of CBT that could be beneficial in helping a client, such as behavioral activation, cognitive restructuring, and mindfulness and acceptance. Michael could use these components to reframe how he currently views his reproductive story, reframing it in a way that helps him process his grief.

Michael could be experiencing disenfranchised grief. This grief is unrecognized and unsupported, a feeling Michael and other men often experience when it comes to pregnancy loss. Working with clients who have experienced this profound loss is best suited for advanced clinicians, as they will know the best ways to incorporate the reproductive story into the sessions, no matter their theory or approach. This intervention could help the client to fully develop and process their reproductive story, helping them reach a place where they can process the pregnancy loss they have experienced, possibly have a relationship with the baby lost, and still potentially feel confident and available to have a relationship with future children.

Implications for Counselors

As society begins to shift and we begin to acknowledge the depth of pregnancy loss, especially for men, counselors will see these clients' reaching out for the assistance they need in processing their grief. While researching the experience of men, there was limited research on support for them versus research showing interventions for couples or their female counterparts. As more research is conducted in this area, having hospitals offer support groups for men, separate from their partners, might help reduce the stigma and give men a voice to help them reduce the alienation they have with their grief. Counselors can incorporate the reproductive story into their approach in a

variety of ways, using it in the best ways to help the client sitting before them. Research has been conducted from different theoretical approaches, such as CBT and attachment theory, but further research exploring it from other approaches could help expand this work even further. A feminist approach, for example, could further explore pregnancy loss from all genders and potentially help further the research in this field. While the reproductive story is a great tool, counselors' have to keep in mind their own reproductive story.

Jaffe (2017) discusses how counselors have their own reproductive story. It does not matter where they are at in life, their story impacts the therapeutic relationship, as counselors often choose this work because of their own pregnancy loss (Marrero, 2013). Counselors who choose to practice with these clients need to be prepared for how they will address their own reproductive story with clients. Counselors should use clinical judgement to determine when it is most appropriate, as every client is different and what is appropriate for one relationship will not be appropriate for another. Counselors need to find awareness of their own story and reproductive trauma, allowing them to use it effectively without risk of countertransference (Jaffe, 2016, 2017). Counselors need to engage in self-care to prevent compassion fatigue and burnout. Professionals can better serve their clients when they are not compromised from the trauma that they are helping their clients with (Killian, 2008). This is particularly true for those who have experienced pregnancy loss, as working with clients who have experienced this as well could be triggering for counselors.

Conclusion

Pregnancy loss is a common, yet tragic event. The disenfranchised grief that goes unacknowledged or mourned with a lack of support complicates the tragedy of pregnancy loss even more (Doka, 1989; Shannon & Wilkinson, 2020). Until society stops dismissing and minimizing the grief of parents, this unrecognized grief will continue in silence by those who suffer most (Lang et al., 2011). Fathers are particularly left to grieve on their own as society expects them to be strong for their partners. Counselors can use the reproductive story to help clients process feelings from childhood through adulthood, as they work through the hopes of what they expected their reproductive story to be (Jaffe & Diamond, 2011). Processing the reproductive story can help clients feel more in control at a time when their story and family feels out of control (Jaffe, 2017). Helping fathers to connect with their identity of being a father and acknowledging how real the baby was to them, can help them to process their grief outwardly.

More research is being done on pregnancy loss and how we can effectively treat the emotional distress that accompanies such a loss. Attachment theory and CBT were two examples of approaches that explored aspects of the grieving process, as well as how to help counselors use these approaches to best serve their clients. This research has primarily focused on women, as pregnancy loss is still seen as a women's issue (McCreight, 2004: Murphy, 1998; Riggs et al., 2018; Rinheart & Kiselica, 2010). This is a viewpoint that needs to shift in research, application, and societal viewpoint. The expectation that men shoulder the weight of their partner's emotions and wellbeing, means that as counselor we should be just as concerned about the wellbeing of men (Rinehart & Kiselica, 2010). In hopes that as counselors we can create an environment where men feel just as comfortable seeking counseling and begin to process their reproductive story.

Counselors using the reproductive story in their approach to counseling can be advantageous to clients who have experienced pregnancy loss. This allows

counselors to be beneficial to their clients, while also incorporating an intervention into an approach they are comfortable with. Counselors needs to do so with discretion, considering their own reproductive story and the effect it could have on the client and the counselor themselves. A counselor who becomes pregnant while working with a client who has experienced loss should explore how the counselor's pregnancy, and thus her reproductive story, impacts the client and the therapeutic relationship. Counselors also need awareness of their own reproductive story so if a client shares about their experience, the counselor can be aware of potential countertransference (Marrero, 2013). Counselor self-care when working with trauma and/or grief must be a priority, especially because those who chose to work with these clients frequently have their own reproductive trauma (Killian, 2008; Jaffe, 2017).

Pregnancy loss is an area that still has research to be done, especially when it concerns men. Men experience the same depth of emotions and grief that women do over pregnancy loss (Renner et al., 2000). Researchers need to fully explore the male experience, to understand what can help them process their grief, in case there are differences that have not been found in the limited research that is available. The reproductive story is universal in that everyone has a reproductive story, even though they have different parts. This is what makes it an intervention that can be used for men, as it looks at them on an individual level, and gives a voice to their grief and experiences that often go unheard.

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Addressing Climate Trauma among Adolescents: Process-Oriented Group Therapy as a Way Forward

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Climate change and climate trauma are producing chronic anxiety, grief, despair, and depression, particularly among adolescents and children. Unfortunately, a sincere discussion of both the mental health implications of climate change and conceptualizations of working through climate trauma has been absent from the counseling literature. We address this gap by examining the impact of climate change on mental health, how individuals cope with climate trauma, and the strong potential of process-oriented group therapy to facilitate healing. Finally, we propose a group therapy model to address climate trauma with adolescents.

Keywords: climate change, climate trauma, adolescence, group therapy, psychotherapy

Current projections of anthropogenic climate change indicate that by the mid-21st century the world will face rising sea levels, more frequent and severe storms, flooding, and droughts, and a wide range of associated challenges related to environmental degradation, heat stress, food scarcity, loss of employment, illness and injury, displacement, and a host of other traumas and losses (Intergovernmental Panel on Climate Change [IPCC], 2014). The consequences of climate change, defined as a change of climate attributed to human activity that alters the composition of the global atmosphere, are already being felt throughout the world and continue to increase as society is unable or unwilling to sufficiently curb greenhouse gas emissions (IPCC, 2014). The United Nations Framework Convention on Climate Change defines climate change as "'a change of climate which is attributed directly or indirectly to human activity that alters the composition of the global atmosphere and which is in addition to natural climate variability observed over comparable time periods" (IPCC, 2014). Locally, climate change is already displacing whole communities in southeast Louisiana as evidenced by the Isle de Jean Charles Resettlement Program (Billiot, 2017). As the world edges closer to catastrophic climate change and humanity begins to feel its traumatic effects, the mental health implications of climate change are increasingly apparent (Hasbach, 2015).

An emerging body of literature has highlighted the need for mental health interventions to respond to the anxiety, depression, post-traumatic stress, and other mental health outcomes provoked by climate change (Büchs et al., 2015; Van Lange et al., 2018; Hasbach, 2015). However, a sincere treatment of climate change and its implications are decidedly lacking within the mental health fields (Büchs et al., 2015; Cunsolo & Ellis, 2018). The counseling field is notably deficient in this area, as a review of all publications in American Counseling Association (ACA) journals reveals not a single article focused on the mental health impacts of climate change.

The categorical silence from the counseling field on this topic is noteworthy as counselors have traditionally played an important role in helping clients face reality, work through issues of denial and resistance, and become hopeful (Hasbach, 2015). The interpersonal nature of counseling would also serve to help clients cope with the abstract and complex nature of the climate change threat by making it more embodied and phenomenological. Our Multicultural and Social Justice Counseling Competencies further call for us to "understand individuals within the

context of their environment" (pp. 30) and the way environmental factors influence the "health and well-being of individuals" (pp.33) (Ratts, et al., 2016). As counselors can reasonably expect to see an increasing number of clients with presenting issues that are directly or indirectly linked to climate change (Berry et al., 2010), clinicians need to be prepared to ethically and competently respond. Accordingly, counseling is not only well-positioned to serve a crucial role in coping with, and working through, the lived experience of climate change, but it also may be an ethical imperative for the field to acknowledge the impact of climate change on clients' psychological well-being.

We posit that process-oriented group therapy is an appropriate therapeutic modality to address the mental health issues related to climate change. Climate change is uniquely group-oriented; it is a collective problem requiring collective solutions. Process-oriented group therapy has the potential to foster productive honest dialogues about the full reality of our environmental crisis and improve the outcomes of related mental health issues. This manuscript starts to address an important gap in the counseling literature by reviewing the data on the impact of climate change on mental health, highlighting the role of group therapy in processing and working through climate change, and outlining how group therapy can be applied to adolescents coping with the realities of climate trauma. Throughout the manuscript, we utilize the term 'climate trauma' to refer to the anxiety, fear, grief, guilt, and distress that are provoked by the concept of climate change and the extensive implications of this environmental crisis for humanity.

Climate Change Impacts on Mental Health

The direct impacts of climate change on mental health predominantly result from exposure to climate-related disasters, including flooding, hurricanes, fires, extreme heat, and droughts (Berry, Bowen, & Kjellstrom, 2010). The experiences of these disasters and their associated losses can result in post-traumatic stress disorder, generalized anxiety, depression, and chronic psychological distress (Berry et al., 2010). In addition to post-disaster mental health concerns, temperature fluctuations and high temperatures adversely affect mental health issues, such as depression (Berry et al., 2010). Individuals may also increasingly experience solastalgia, which describes feelings of desolation or homesickness that result from meaningful landscapes, ecosystems, and species disappearing or changing beyond recognition (Hasbach, 2015). Support for mental health services will become increasingly important as people not only cope with extreme climate-related events, but are also forced to adapt to a new normal that is marked by continuous disruption of environmental and social conditions (Cunsolo & Ellis, 2018).

Indirect impacts on mental health are also noteworthy as social systems, interpersonal interactions, and the socioeconomic determinants of health shift amidst climate change (Berry et al., 2010). Higher temperatures, disasters, and resource competition are expected to increase social exclusion, displacement, and violence (Pearson & Schuldt, 2018). Climate change will also elevate levels of economic insecurity and unemployment, both of which are linked to poor mental health outcomes (Berry et al., 2010). Some individuals may also need to work different or longer hours, which may result in less time spent with loved ones and reduced

social connectedness (Berry et al., 2010). Additionally, climate change is expected to impact physical health due to heat stress, injury, disease, and disruption to food and water supplies, all of which have been shown to influence mental health (IPCC, 2014; Berry et al., 2010). Climate change projections also predict the emergence of new infectious disease as a result of changing climatic conditions (IPCC, 2014). While there is no evidence of a direct connection between climate change and the Coronavirus disease (COVID-19), climate change does indirectly impact COVID-19 response by adding additional stress to health systems and impacting the environmental determinants of health (World Health Organization, 2020). Taken in their totality, the anticipated direct and indirect impacts of climate change loom as a significant threat to mental health.

Climate Trauma

While numerous studies have examined the direct and indirect impacts of climate change on mental health, the cumulative impact of existing within the climate crisis is rarely recognized (Cunsolo & Ellis, 2018). Woodbury (2019) coined the term "climate trauma" to describe an "entirely new, unprecedented, and higher-order category of trauma" (pp. 1) that results from living with the all-encompassing nature of the climate change threat and its implications for social existence. Woodbury (2019) argues that since climate change involves fundamental changes to the planet, "the climate crisis calls into question our basic relationship to nature, and what it means to be human in the Anthropocene" (Woodbury, 2019, pp. 5). The concept of climate trauma acknowledges the lived experience of people in distress throughout the world as they wrestle with the knowledge that we are in the midst of profound and irreversible changes (Woodbury, 2019). According to Woodbury (2019), climate trauma affects everyone, although individual responses to climate trauma differ. While some clients may be aware they are experiencing climate trauma (Büchs et al., 2015), others may not be cognizant of the links between their distress and climate change (Gifford, 2011; Hasbach, 2015). Meaningfully existing within this traumatic global disruption requires authentically addressing how interrelated and interdependent we all are (Pearson & Schuldt, 2018).

Coping with the Climate Change Threat

Climate change is an overwhelming threat to comprehend, accept, process, and address. Several studies have highlighted how the climate crisis overwhelms our emotional capacity, triggers past personal, cultural, and intergenerational traumas, and provokes existential anxiety by challenging the idea of a shared future and our collective sense of order (Büchs et al., 2015; Gifford, 2011; Myers, 2014; Ojala, 2016; Woodbury, 2019). As Kidner (2007) aptly summarized:

> Staring reality, and not least ecological reality, in the face can indeed be unbearable, and it is therefore unsurprising that many of us engage in mental gymnastics in order to avert the full psychological impact of the destruction of the natural world. (pp. 140)

Mental gymnastics take many forms and influence one's response to climate change.

Numerous articles have highlighted the myriad of factors that prevent individuals from thinking and/or acting on climate change (Gifford, 2011; Van Lange, Joireman, & Milinski, 2018). First, common emotional responses to the overwhelming implications of climate change challenge include feelings of distress, anxiety, grief, and/or guilt. For some, these underlying emotions may be so

difficult and powerful that a protective mechanism takes over and the person instead expresses fear, anger, dissociation, denial, and/or paralysis (Gifford, 2011; Myers, 2014).

Second, humans have an innate tendency to focus on immediate and personal threats (Gifford, 2011). As a result, the brain encourages individuals to underestimate or undervalue a threat that is spatially or temporally distant. In the case of climate change, the impacts of climate change are often felt most in the geographic regions that contributed the least to greenhouse gas emissions, and changes in climate inherently occur on long time scales (IPCC, 2014). These traits making it even more difficult for an individual to consider climate change as a serious threat. Individuals may instead seek out excuses or arguments that allow them to avoid viewing climate change as a significant danger, such as claiming to not know that a problem exists or not knowing what actions one can take after becoming aware of the problem (Gifford, 2011). These excuses and arguments may manifest as ignorance or uncertainty about climate change (Gifford, 2011).

Third, there are ideological barriers to addressing climate change, such as religious beliefs in a superhuman power and worldviews valuing free market capitalism and individualism (Gifford, 2011; Ojala, 2016). Full recognition of the climate change threat challenges these strongly held beliefs and values. For example, someone might believe that a religious deity will do what it wants despite any climate-related action (Gifford, 2011). Individuals that strongly support free-market ideology are likely to hold strong beliefs in efficiency, economic growth, and techno-optimism, which have been found to result in environmental apathy or overconfidence in the potential for current technologies to fully address climate change issues (Gifford, 2011; Heath & Gifford, 2006). Feelings of powerlessness can also fuel system justification and tendencies to defend one's identity, status, and the status quo (Büchs et al., 2015; Gifford, 2011; Pearson & Schuldt, 2018). Many individuals are financially and socially invested in the current system, and environmental issues are not given priority over other needs (Gifford, 2011). For example, Steentjes et al. (2017) examined social norms around climate change and racial equality, concluding that the social cost of confronting climate change disregard is higher than the social cost of confronting racial prejudice. Their study highlighted that individuals view confrontation on climate change as morally ambiguous and that even polite confrontation on climate change topics can incur social sanctions (Steentjes et al., 2017). People have also made financial investments in carbon-intensive products (Steentjes et al., 2017; Gifford, 2011). For example, people are also less likely to use bicycles or public transportation if they already own a vehicle since they would see not driving the car as wasting the money that has already been invested and failing to take advantage of the benefits of the car (Gifford, 2011). As a result of emotional distress, cognitive dissonance, and ideological challenges, climate change is minimized, denied, or avoided altogether (Büchs et al., 2015; Myers, 2014; Woodbury, 2019).

These emotional, cognitive, and ideological protective mechanisms are often reinforced socially. Social norms, perceived inequity, and comparison to others' actions have been shown to stifle climate change action (Gifford, 2011; Pearson & Schuldt, 2018). For example, when homeowners were told the average amount of energy that their neighbors used, homeowners increased or decreased their consumption to fit the norm (Gifford, 2011). Although

several pro-environmental actions have been encouraged in Western societies (e.g., recycling, driving hybrid vehicles), these actions themselves are insufficient and can result in individuals feeling justified in engaging in other environmentally-damaging behaviors (Gifford, 2011). As a collective issue, climate change action is also stifled by the fact that people are less inclined to take action when they believe their actions will have minimal impact and that they cannot control the ultimate outcome (Büchs et al., 2015; Gifford, 2011; Stevenson & Peterson, 2016).

It is increasingly important to recognize, process, and work through feelings of grief, despair, denial, ignorance, apathy, and other emotions in relation to climate trauma. Failure to facilitate humans' capacity to do so, both on an individual and collective level, will likely ensure that we are unable to meaningfully cope with climate trauma. This is particularly true for children and adolescents (Nairn, 2019; Ojala, 2016).

Adolescents and Climate Trauma

In this section, we briefly outline three key reasons why it is imperative to address climate trauma among adolescents. First, climate trauma is already manifesting among young persons (Ojala, 2012). Over the past ten years, youth have been inundated with messages about dire climate change projections and the failure of older generations to resolve this manmade problem (Stevenson & Peterson, 2016). It is unsurprising that children and adolescents are increasingly worried, anxious, pessimistic, and distressed by climate change (Nairn, 2019; Ojala, 2016).

Second, children and adolescents today will transition into adulthood and positions of leadership at a time when the brunt of climate change hits society and ecosystems (Ojala, 2012; Stevenson & Peterson, 2016). Whereas climate change is a temporally distant threat to today's adults, young persons will have no choice but to confront the issue of climate change (Ojala, 2012; Stevenson & Peterson, 2016). It is thus increasingly important to engage young persons in climate change dialogues (Ojala, 2016).

Third, addressing climate trauma among adolescents has the potential to alter the trajectory of how humanity processes and responds to the climate change threat. Duncan, Hall, and Knowles (2015) have argued that psychological work with adolescents can make meaningful impacts on their psychosocial trajectory. Developmentally, adolescence is marked by the formation of identity, including the development of a moral value system and preparation for the future (Malekoff, 2015). Furthermore, adolescents continue to develop emotional regulation, impulse control, consequential thinking, and decision-making functions into their mid-20s (Duncan, Hall, & Knowles, 2015; Malekoff, 2015). Successful development of these skills are critical in the capacity to engage in a complex and abstract phenomena like climate change.

There is thus a need to not ignore or pathologize the anxiety felt by adolescents in response to climate change. Rather, anxiety is a natural response to an existential threat and can be leveraged as the catalyst for productive and meaningful development. Several therapeutic modalities can trace their origins to the existential crisis that emerged amidst the terrifying destructive capacity of the nuclear bomb and are designed precisely to help humans navigate existential threats like climate change (May, 1994; Tillich, 1957). There is thus an opportunity and need for mental health professionals to work with adolescents on climate trauma issues.

Addressing Climate Trauma: Process-Oriented Group Therapy with Adolescents

Process-oriented group therapy has been an effective therapeutic approach to help individuals cope with loss and facilitate honest emotional expression without feeling overwhelmed (Paine et al., 2017). While there is a current lack of evidence for group therapy to address the mental health issues associated with ongoing climate change, therapeutic techniques for disaster events could provide helpful insights to addressing climate trauma given the interrelated nature of climate change and specific disaster events (Berry et al., 2010). There is evidence across diverse settings that group therapy can improve mental health outcomes for adolescents and children after a specific disaster event or trauma (Pityaratstian et al., 2015; Salloum, Garside, Irwin, Anderson, & Francois, 2009). Additionally, since climate change brings more frequent and severe climate-related events, clients will increasingly experience the direct and indirect impacts of specific disaster events, in addition to mental health issues related to the ongoing, abstract nature of climate change (Berry et al., 2010). Group therapy is particularly appropriate for adolescents due to the value of peer relationships in this developmental stage (Malekoff, 2015). Group therapy helps adolescents build the ability to consider multiple viewpoints and engage in meaningful debates, learn how to seek support and be useful to others, and believe in a hopeful future (Malekoff, 2015). These skills are indispensable if we are to address climate change in a healthy and productive manner (Nairn, 2019; Ojala, 2016).

Group therapy is uniquely positioned to address climate trauma given the inherently collective nature of climate change causes and potential solutions (Pearson & Schuldt, 2018). Social norms, intergroup contact, and social embeddedness are among the many factors influencing how individuals perceive and respond to climate change (Büchs et al., 2015; Steentjes et al., 2017). It is thus unsurprising that processing climate trauma strongly aligns with Irving Yalom's (1995) therapeutic factors of group therapy. Yalom (1995) identified eleven therapeutic factors in group therapy, including instillation of hope, universality, imparting information, altruism, interpersonal learning, development of socialization techniques, corrective recapitulation of the primary family group, imitative behavior, existential factors, catharsis, and group cohesiveness. These therapeutic factors come together in group therapy to foster a space in which the group can perform optimally and maximize its therapeutic benefit for members (Yalom, 1995). In Table 1, we summarize the various ways in which each therapeutic factor is relevant in the context of group therapy for adolescents working on climate trauma issues.

Table 1. Therapeutic Factors for Group Therapy with Adolescents for Climate Trauma

Group Therapy Therapeutic Factor Source: Yalom, 1995	**Significance of Factor for Climate Trauma Group Therapy with Adolescents**	**Potential Utilization of Factor in Climate Trauma Group Therapy with Adolescents**
Instillation of hope, including the belief that group therapy will be effective and that the current situation can and will improve.	There is widespread evidence highlighting the pervasiveness of hopelessness and powerlessness in relation to the climate change threat, particularly among younger populations (Ojala, 2016).	Interpersonal connection, support, and feedback on the impact of individual and collective actions can foster feelings of empowerment and self-efficacy to think about and find ways to act on climate change (Hasbach, 2015).
Existential factors, including issues of life, death, freedom, responsibility, and meaning	Climate change itself is an existential threat, forcing clients to re-frame human-nature relationships, lifestyles, and social existence (Myers, 2014; Woodbury, 2019).	Group therapy is an opportunity to discuss the existential aspects of climate change and to find personal and collective meaning (Büchs et al., 2015; Myers, 2014).
Universality, including highlighting the similarities among group members and the relief that comes from not feeling alone in struggle	Climate change will have impacts on every individual and every community (Pearson et al., 2016). Strong emotional responses to climate change are increasingly common but not often identified and recognized (Berry et al., 2010).	Group therapy is an opportunity to highlight the universality of climate change; we all share the identity as a perpetrator and victim of climate change (Woodbury, 2019). Clients may find relief from meeting others with similar concerns about climate change (Büchs et al., 2015).
Corrective recapitulation of the primary family group, including increasing awareness and making changes to distortions, roles, and attitudes that stem from early familial conflicts and dynamics	Climate change provokes strong emotions that will be managed according to clients' learned ways of coping with distress (Gifford, 2011). Meaning-focused coping strategies for climate change are most strongly linked with hope and action, yet these strategies require trust in societal actors (Stevenson & Peterson, 2016).	Group therapy is an opportunity to recognize how the primary family group has influenced one's responses, distortions, and assumptions related to societal actors and peers. By working through these issues, clients can potentially overcome mental blockages (Gifford, 2011; Stevenson & Peterson, 2016) .
Imitative behavior, including vicarious spectator therapy and imitation of counselor or member behavior	Social norms play a strong role in promoting or discouraging climate change dialogues and action, and individuals are more likely to engage in pro-environmental behavior when they perceive that others are doing it (Pearson & Schuldt, 2018).	Group therapy is an opportunity to establish group norms that normalize honest dialogues about climate change (Steentjes et al., 2017).

Group Therapy Therapeutic Factor Source: Yalom, 1995	**Significance of Factor for Climate Trauma Group Therapy with Adolescents**	**Potential Utilization of Factor in Climate Trauma Group Therapy with Adolescents**
Imparting information, including didactic instruction, direct advice, suggestions, and guidance	Lack of knowledge about climate change and its consequences remains a barrier to processing the issue and taking action (Gifford, 2011). There is limited knowledge and among the public on the cognitive, emotional, and social ways people respond to the concept of climate change (Ojala, 2016).	Didactic instruction related to climate change and psychoeducation on mental health responses to climate change can enable clients to more effectively engage with others in dialogues on climate change (Van Lange et al., 2018; Ojala, 2016;).
Catharsis, including emotional discharge and transformative moments of gaining new and/or deeper insight	Studies suggest that transformation at individual and societal levels are needed to address climate change; without a disruption to the status quo, all other solutions will be too little and too late (Myers, 2014).	Group therapy can create a safe space in which individuals can work through the overwhelming reality of climate change and reach a new state characterized by acceptance, concern, and hope (Myers, 2014).
Altruism, including the value of giving to others and the importance of feeling needed and useful	The myth of self-interest has increased reluctance to take individual action (Van Lange et al., 2018). The enormity of the climate change problem is also overwhelming and can make clients feel insignificant (Gifford, 2011).	Group therapy is an opportunity to dispel the myth of self-interest and establish new social norms that empower individual action (Van Lange et al., 2018). For clients feeling insignificant and powerless, altruism in group therapy can provide solace by feeling needed and important in the group (Büchs et al., 2015).
Development of socializing techniques, including development of social skills and increased understanding of impression leave on others	Social skills are needed to effectively communicate with others about climate change, both to be able to process one's own thoughts and feelings and to confront social norms that perpetuate climate change denial and inaction (Gifford, 2011; Myers, 2014; Steentjes et al., 2017).	Learning new skills through group therapy can enable clients to effectively engage with others on climate change topics without incurring significant social costs (Steentjes et al., 2017).
Group cohesiveness, including emotional connectedness, acceptance of self and others, solidarity and attachment to the group, and group effectiveness	Feeling connected to and belonging in a group has helped individuals process difficult emotions related to climate change and fostered pro-environmental action (Büchs et al., 2015; Elf et al., 2018).	Developing a social identity through group membership has the potential to deepen and facilitate one's engagement in challenging topics like climate change (Pearson et al., 2016).

Group Therapy Therapeutic Factor Source: Yalom, 1995	**Significance of Factor for Climate Trauma Group Therapy with Adolescents**	**Potential Utilization of Factor in Climate Trauma Group Therapy with Adolescents**
Interpersonal learning, including interactions that result in a corrective emotional experience and highlight societal dynamics and meanings as a social microcosm	Intergroup interactions have the power to reduce intergroup conflict and foster collective action (Pearson & Schuldt, 2018). Minorities will be disproportionately impacted by the adverse effects of climate change and there are ethic/racial, gender, and socioeconomic disparities in how people perceive and respond to the climate change threat (Pearson et al., 2016; Stevenson & Peterson, 2016).	Overcoming emotional and social roadblocks to thinking about climate change will require a corrective emotional experience in talking about climate change issues and its implications for self and society (Büchs et al., 2015). Group therapy has the potential to highlight equity issues related to climate change and to help members explore new ways of addressing both equity and climate change issues (Pearson et al., 2016).

Given the inherent alignment between group therapy and climate trauma issues, process-oriented group therapy appears an ideal therapeutic modality to address climate trauma. Rather than reinvent the wheel to address the complex issue of climate trauma, we assert that leveraging the current practice of process-oriented group therapy can help adolescents navigate the symptoms associated with climate trauma and develop the capacity to meaningfully engage with the abstract and future-oriented nature of the climate change threat.

Navigating the Symptoms Associated with Climate Trauma in a Group Context

Process-oriented group therapy has the potential to create insight into how individuals cope with the threat of climate change and to support a profound examination of climate change, its meaning, and its implications. Meaningful engagement with climate change calls for individuals to acknowledge despair while also activating positive emotions in order to avoid overwhelming paralysis (Ojala, 2016). However, adolescents are increasingly overwhelmed and exasperated by the climate change threat (Nairn, 2019; Ojala, 2012), which is a normal and universal response to such a complex issue. Process-oriented psychotherapy group can benefit adolescents through its emphasis on the "here-and-now" (Yalom, 1995, p. 129). Intentionally focusing on immediate experience can prevent conversations on climate change from becoming abstract and overwhelming. Illuminating the process of the group's interactions can also be useful to work through the protective mechanisms employed to cope with the overwhelming nature of climate change (Paine et al., 2017). Group therapy also provides a space to work through family of origin issues, leading to insights into individuals' coping strategies and the ways they process the climate change threat itself (Yalom, 1995).

The high level of distress that is likely to occur in this process necessitates the creation of a safe environment that will allow individuals to move through their mental roadblocks in relation to climate change (Yalom, 1995). Notably, clients will inevitably have different abilities and interest levels in expressing certain emotions and thoughts related to climate change (Büchs et al., 2015). Process-oriented group therapy is well-suited to work with these differences by creating an

environment in which one's coping strategies can play out in a safe and authentic interpersonal space (Paine et al., 2017). Without an intentional and safe environment, it is unlikely that many adolescents would be able to commit to such difficult work and successfully develop a more livable and honest narrative about the world and their reality.

Furthermore, building a community and a sense of universality in the face of the climate change reality is critical to healing and growth (Nairn, 2019). Given the limited dialogue in public and social spheres on climate trauma and its existential implications (Cunsolo & Ellis, 2018), group therapy for climate trauma may be the first time an individual articulates their deep fears around climate change. Adolescents are likely to feel less alone by sharing their concerns with the group and listening to others express similar concerns.

The Role of Group Therapy in Climate Change Action

Productive engagement with climate change, particularly in a group format, has the potential to inspire collective action and pro-environmental behavior (Büchs et al., 2015). However, while some members may channel their energies into identifying and implementing actions to ameliorate the causes and/or impacts of climate change, others may not take part in pro-environmental efforts. Additionally, the solutions for climate change are wide-ranging and it is important that the group not become a vehicle for indoctrination about the 'correct' way to respond or act. Becoming too focused on outcomes and solutions can hinder the growth process for members. For this reason, climate change action should not be an explicit objective of the group. Instead, when addressing external complex problems, it is important that the group's emphasis remain on bolstering the client's capacity to actively engage with their phenomenological experience and not retreat to avoidant coping or naïve problem solving. The group is better served if the emphasis remains on strengthening a client's ability to face the reality of climate change and its implications for the world and human survival.

Emerging Evidence on Group Therapy for Climate Trauma: A Call for Further Research

There is limited research on the potential of group therapy to address climate trauma. There are, however, a few examples of group therapy for climate trauma in practice (Büchs et al., 2015; Preston, 2017). Carbon Conversations is one prominent example that fosters engagement with climate change issues by applying group therapy techniques (Büchs et al., 2015). Participants in Carbon Conversations reported feeling more confident in influencing others about climate change and in taking action to reduce their carbon footprint (Büchs et al., 2015). In an online survey with 113 group participants, 78 per cent agreed or strongly agreed that taking part in Carbon Conversations helped them "take action to reduce their overall carbon footprint" and 66 per cent agreed or strongly agreed that their participation in the group helped them to "be confident in influencing others about climate change" (Büchs et al., 2015). Half of survey participants agreed that the group helped them to face their worries about climate change (Büchs et al., 2015). In semi-structured interviews with 26 participants, individuals reported experiencing higher levels of distress when they learned more about climate change (Büchs et al., 2015). Interviewees also stated that the group helped them to express and share difficult emotions and that listening to others facilitated personal reflection on the topic (Büchs et al., 2015).

Importantly, this group was not explicitly process-oriented and exclusively targeted adults. While further research is needed on the efficacy of climate trauma groups and their application with adolescent populations, group therapy is well-positioned to facilitate healthy development around climate change issues and support adolescents' capacity to transcend the debilitating effects of climate trauma.

Conclusion

In conclusion, climate trauma is an increasingly urgent issue that needs to be recognized and addressed within the counseling field. Given the group-oriented nature of climate change and the strong alignment between climate trauma and the therapeutic factors for group therapy, we assert that group therapy is the appropriate modality to explore and work through issues related to climate trauma. Process-oriented group therapy for adolescents with climate trauma provides an opportunity to process emotions, thoughts, and beliefs related to climate change in order to deepen clients' abilities for honest engagement with climate change and its implications. Process-oriented group therapy for adolescents with climate trauma is a promising starting point for healing in the face of the climate change reality

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History of School Counseling in Louisiana

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Understanding our history gives insight and understanding of our current position. Examining historical events and trends enables us to appreciate our present and help us plan for the future. The purpose of this article is to explore the history of school counseling in Louisiana from the 1920s to the present day. The literature examined includes dissertations, publications of professional organizations, current law and proposed laws, task force and organizational reports, and personal communications from school counseling professionals and others. The literature contained in this article dates from 1925 to the present date. It is clear from this review of school counseling history in Louisiana that professional advocacy has been required of school counselors in Louisiana since the inception of the profession. While attempts have been made in the legislature over the years to increase the number of school counselors and reduce non-counseling duties, our progress has been slow.

Keywords: Louisiana school counselor, Louisiana school counseling, history

Throughout history, education has evolved and been shaped by social, political, economic, and cultural influences. School counseling is a profession that grew out of the vocational guidance movement in the late 19th century. Referred to interchangeably over the past 140 years as guidance, vocational guidance, and school counseling, the profession has continuously evolved, influenced by the same forces that have impacted our educational system. The title, identity, roles, and responsibilities of school counselors have been impacted by the social, political, economic, and cultural changes. School counseling in Louisiana is almost as old as the profession itself, with early beginnings; however, it has struggled to keep up with changes at the national level.

The 1920s

Louisiana had an early start implementing school counseling programs. Emma Pritchard Cooley is considered the founder of Louisiana's vocational guidance movement (Chilton, 1982). Cooley was born in Pointe Coupe Parish and graduated from the New Orleans Public School System (Chilton, 1982). She began her career at the age of sixteen as a Latin teacher in Amite, Louisiana (Chilton, 1982). Cooley's post-graduate education included Tulane University, Boston University, and training in Paris, France (Chilton, 1982). While at Boston University, in 1914, Cooley was a student of Meyer Bloomfield (Brewer, 1942), the founder of today's National Career Development Association (NCDA), and the Journal of Counseling and Development (Savickas, 2009). Bloomfield is also known for teaching the first counselor education course offered in the United States in 1911 at Harvard University summer school before teaching at Boston University, where Cooley was his student (Savickas, 2009). In 1918, Cooley joined the war effort and served as a Red Cross worker in Albania until 1920 (Brewer, 1942). During her time in Albania, Cooley met many people interested in the guidance movement in their communities of Boston, Philadelphia, and New York (Norton, 1962, as cited in Chilton, 1982). On her return to the United States following her service, Cooley visited the programs offered in these cities (Norton, 1962, as cited in Chilton, 1982). When she returned

home to Louisiana, Cooley convinced the New Orleans Public Schools Superintendent, Joseph Gwinn, to establish guidance programs in high schools in New Orleans on an experimental basis from 1921-1923 (Norton, 1962, as cited in Chilton, 1982). She offered this as a solution to combat a high dropout rate among seventh- and eighth-grade students (Norton, 1962, as cited in Chilton, 1982).

In September 1921, Cooley was appointed as a visiting teacher, and the Department of Vocational Guidance was created in the New Orleans Public School System (Chilton, 1982). A study was undertaken by Cooley to determine the reason for the dropout problem (Chilton, 1982). According to Cooley (1925), students were dropping out of school due to "discouragement, maladjustment in courses of study, and from an adventurous spirit" (p. 30), not to work and support their family. It was determined that about 13% of the students who left high school did so out of financial necessity (Cooley, 1925).

Cooley implemented a plan that resulted in 324 of 379 high school graduates becoming successfully employed by January 1922 (Romeo, 1938, as cited in Chilton, 1982). Over the summer of 1922, Cooley helped over 200 young people plan their school courses (Chilton, 1982). Cooley requested a meeting with both secondary and elementary school principals to generate interest in counseling services (Chilton, 1982). As a result, the principals petitioned the school board to have counselors placed at every school in New Orleans (Chilton, 1982). The request was approved for the secondary schools only (Chilton, 1982). In 1923, teachers were appointed as counselors in two New Orleans high schools; however, no time was set aside for counseling activities until 1925 (Brewer, 1942; Cooley, 1925, as cited in Chilton, 1982). Cooley continued to advocate for the hiring and placement of elementary school counselors, and by 1924, three elementary schools had employed a counselor (Chilton, 1982). Cooley's advocacy efforts had a monumental impact. By the end of the 1926-1927 school year, the vocational guidance program was well established in New Orleans Public Schools, including counseling programs in all secondary schools and eight elementary schools (Romeo, 1938, as cited in Chilton, 1982).

The 1930s

By 1932, all elementary and high schools in New Orleans had a counselor; however, the time allotted for counseling activities was limited (Chilton, 1982). That same year, the school board budget was decreased by $372,619. Special programs, including vocational guidance, were to be eliminated. Cooley advocated before the board, insisting that the cuts would harm public education, and the board reversed its decision (Romeo, 1938, as cited in Chilton, 1982). Cooley's advocacy and leadership in vocational guidance and counseling continued when she served as president of the National Vocational Guidance Association (NVGA) from 1930-1931 (National Career Development Association [NCDA], n.d.).

As a result of the New Orleans Public Schools' program's success, a guidance and counseling curriculum began at colleges and universities around the state, including Tulane and Loyola Universities in New Orleans, Louisiana State University (LSU) in Baton Rouge, and Louisiana State Normal College, now Northwestern State University, in Natchitoches in the 1920s (Chilton, 1982). Between the years 1932-1936, LSU taught on-campus graduate courses in guidance and eventually offered a master's degree in guidance beginning in 1936 (Louisiana

Leader, 1936, as cited in Chilton, 1982).

The Louisiana Department of Education (LDOE) also noticed the New Orleans guidance program's success. Following the depression, Louisiana State Superintendent of Education, T.H. Harris, recommended an educational guidance program for Louisiana Public Schools (Chilton, 1982). Superintendent Harris appointed a state guidance committee that included H.L. Garrett of LSU as the chairman, Emma Pritchard Cooley of New Orleans, and others (Chilton, 1982). The committee's purpose was to develop a statewide guidance program for Louisiana public schools (Chilton, 1982). In 1938, the State High School Supervisor, John Coxe, recommended to parish superintendents that a guidance program should be in every high school (Chilton, 1982). Coxe became the state superintendent of education in 1940 (Chilton, 1982). During that time, he requested that the state board of education readopt the state's plan for vocational education with amendments to include the appointment of a supervisor for occupational information and guidance (Chilton, 1982).

The 1940s

A plan of "wartime guidance" was adopted in early 1942 (Chilton, 1982). Recognizing that high schools were preparing students for military service (Ewerz, 1944, as cited in Chilton, 1982), the primary guidance activities included developing individual student inventories and disseminating occupational information (Chilton, 1982). The first known Career Day was sponsored by Ponchatoula High School in 1943 (Louisiana Education in Wartime, 1943, as cited in Chilton, 1982). The career day at Ponchatoula High School was supported by Elmer E. Puls who was appointed as the first supervisor of guidance at the state level in 1942 (Chilton, 1982). Puls left the LDOE in 1944, and his position was left vacant for the next six years (Chilton, 1982).

In 1944, State Representative Stewart S. Kay, of DeRidder, LA, offered a bill to provide an allotment of funds for vocational agriculture education and related fields, which included guidance (Chilton, 1982). This appropriation was the first of its kind that included guidance services (Chilton, 1982). Governor J. H. Davis vetoed the appropriation for the first fiscal year, but the bill did become law in 1945 (Chilton, 1982). The funds provided by the Kay Bill were intended to expand vocational guidance and were not specified to be appropriated toward a particular service; however, they could be used to pay the salary of counselors and directors of guidance and for professional development (Chilton, 1982). The recommended duties for counselors included counseling, providing occupational information, placement, conducting career days and college days, and providing counseling to parents as needed (Ewerz, 1945, as cited in Chilton, 1982). The Kay Bill was re-appropriated in 1946, expanding appropriations for current guidance programs or for developing new ones (Coxe, 1946, as cited in Chilton, 1982).

While New Orleans Public Schools already had a thriving guidance program, vocational guidance had not expanded across the state (Chilton, 1982). In 1944, Lydie Sommer, a teacher at Istrouma High School, attended a workshop on guidance (Sommer, 1981, as cited in Chilton, 1982). Sommer was hired as a full-time counselor at Istrouma in 1945, serving as the first counselor in East Baton Rouge Parish, a position she kept until she retired 21 years later (Sommer, 1981, as cited in Chilton, 1982). In Tangipahoa Parish, Ponchatoula High School was

designated by the State Board of Education to serve as a pilot school in guidance, beginning in July 1949 (Chilton, 1982). The position was filled by a former teacher trained at Mississippi Southern College (Chilton, 1982). Over the next four years, four hours each day were allotted to guidance activities (Davis, 1950, as cited in Chilton, 1982).

The 1950s – 1960s

In 1950, Margaret Colvin was appointed as supervisor of the Guidance Section in the LDOE following a vacancy after Puls left the position in 1944 (Chilton, 1982). During her tenure as Supervisor of Guidance, Colvin expanded the vocational guidance definition to include "life adjustment." She acknowledged the importance of teamwork, social skills, and coping skills for success in the workforce. She also articulated that school counselors were best equipped to address life adjustment (State Department of Education Annual Report, 1951, as cited in Chilton, 1982). As a result of the advocacy of Margaret Colvin, Louisiana established minimum certification requirements for guidance personnel in 1947; those requirements were revised in 1952 and 1956 (Nugent, 1957; Chilton, 1982). In 1952, the certification requirements for the position of full-time guidance counselor included:

> a valid Louisiana teaching certificate based on a college degree and three years successful experience as a teacher, counselor, supervisor, and/or administrator. In addition, the applicant had to have a master's degree from a regionally-accredited institution. Graduate training must have included a total of fifteen semester hours of professional courses distributed so that at least one course was taken from each of the five basic areas listed below (1) the organization and administration of guidance, (2) analysis of the individual, (3) educational and occupational information, (4) counseling, and (5) principles of guidance. (Chilton, 1982, p. 111)

Any teacher who devoted more than half their time to counseling was required to have this certification (Chilton, 1982).

The certification requirements made clear the need for graduate programs, specifically in counseling. Louisiana State University, since 1936 had been the only college in Louisiana to offer a master's degree in guidance counseling (Chilton, 1982). Four other colleges offered courses in guidance and counseling: Southwestern Louisiana Institute at Lafayette (now the University of Louisiana at Lafayette), Southeastern Louisiana College at Hammond, Leland College (a historically black private college in Baker, Louisiana that closed in 1960), and Loyola University (Chilton, 1982). In 1954, Northwestern State College, now Northwestern State University, in Natchitoches, LA, became the second college in Louisiana to offer a master's degree in guidance counseling (Chilton, 1982).

Around the same time, in 1954, under the leadership of Margaret Colvin, the Louisiana Guidance Association (LGA) was chartered by 33 school guidance counselors and one mental health professional (Chilton, 1982). The group was made up of white school counseling professionals at all levels in public and private institutions and was associated with the Louisiana Teacher's Association (LTA), also an all-white organization (Chilton, 1982; Louisiana Association of Educators, 2017). Marjorie Longsdorf served as the first president of LGA (Chilton, 1982). There was also an organization of African American school counselors

affiliated with the Louisiana Education Association (LEA), a statewide African American teachers association (Chilton, 1982; Louisiana Association of Educators, 2017).

Following Russia's launch of Sputnik, the US passed the National Defense Education Act (NDEA; 1958), which provided funding for guidance, testing, and school counseling programs. Louisiana later benefited from funding associated with the passage of three laws, (1) the Vocational Education Act (1963), (2) an expansion to NDEA (1964), which provided funding for elementary school counselors, and (3) the Elementary and Secondary Education Act (1965). As required by NDEA, in 1959, Louisiana submitted to the United States Commissioner of Education the state plan for guidance counseling and testing (Chilton, 1982). The plan mandated certified guidance counselors at a ratio of one counselor for every 400 students (Jackson, 1959, as cited in Chilton, 1982). With the expansion of NDEA funding for elementary guidance programs, Louisiana piloted programs at six elementary schools in three parishes (Chilton, 1982). In 1962, the Louisiana Legislature passed a law that defined "guidance counselor," "guidance director," and "practice of school guidance counseling" (La. Admin. Code tit. 28, CXVI §3002)

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The 1960s – 1970s

In the early 1950s, national organizations were merging, and counseling was becoming more streamlined, while in Louisiana through the 1960s and 70s, multiple counseling organizations were forming, and mergers were evasive. The American Personnel and Guidance Association (APGA) emerged in the early 1950s from the combination of several organizations dedicated to counseling while the NVGA maintained its status as a division of the APGA (Picchioni, 1980). Following the 1967 APGA convention in Dallas, Texas, a Louisiana delegation decided to form a state branch (Vogel, 1982 as cited in Chilton, 1982). On April 10, 1968, the Louisiana Personnel and Guidance Association (LPGA) was granted a charter during the APGA 1968 convention (Vogel, 1982, as cited in Chilton, 1982). Alice Fassitt Jupiter, an African American woman who served as a teacher and school counselor in the New Orleans Public School System for 45 years was a charter member of the LPGA (Alice Fassitt Jupiter Obituary, 2012). The LPGA and the LGA held a meeting together in March 1969 to discuss combining school counselors who were members of LEA with members of LGA for the purpose of improving counseling services in Louisiana (LPGA minutes, 1969, as cited in Chilton, 1982). In 1970, the Louisiana School Counselor Association (LSCA) was issued a division charter to the American School Counselor Association (ASCA; L. Moriarty, personal communication, August 26, 2020). Agnes Shaw served as the first president (LSCA, n.d.). The LPGA neither rejected nor accepted the newly formed 100-member LSCA organization, and the 500-member LGA organization had not affiliated with LPGA (Taylor, 1971 as cited in Chilton, 1982). There was a continued push for integrating the professional organizations for school counselors with a group from both LGA and LSCA advocating for affiliation with the African American school counselors of LEA (Taylor, 1971, as cited in Chilton, 1982).

In September 1971, LGA and LSCA officially merged to become a single organization for school counselors affiliated with the LPGA (LSCA, 1971, as cited in Chilton, 1982). LSCA also requested LTA and LEA affiliation to enhance professional identity and unify the profession (LSCA, 1971, as cited in

Chilton, 1982). In 1971, LSCA's Political Action Committee (PAC) was involved four advocacy efforts including (1) for school counselors to be included in the teacher allotment formula, (2) for school counselors to receive tenure, (3) for school counselors to get financing for relevant professional development, and (4) for a state-mandated counselor-pupil ratio (Taylor, 1971, as cited in Chilton, 1982). As a result of the advocacy efforts, the Louisiana Board of Elementary and Secondary Education (BESE) passed a resolution at its May 11, 1972 meeting that called for elementary and secondary schools to provide trained and certified counselors (Dawson, 1972, as cited in Chilton, 1982). This resolution was to be fully implemented by July 1, 1977, with demonstrated progress each year toward the goal (Dawson, 1972, as cited in Chilton, 1982). Unfortunately, the state legislature did not appropriate any money toward funding this resolution (Bacle, 1972, as cited in Chilton, 1982).

During the 1970s, certification requirements for secondary school counseling were made more rigorous (Chilton, 1982). The requirements included a valid teaching certificate in secondary education with three years of experience at the secondary level; however, an applicant could substitute one year of accumulated occupational experience for one of the three years of experience (Chilton, 1982). The applicant also had to hold a master's degree that included 21 hours of professional courses (Chilton, 1982). Furthermore, the state implemented certification requirements for elementary school counselors for the first time that included a master's degree with 21 credit hours in seven counseling areas and three years of teaching experience on a valid teaching certificate (Chilton, 1982).

The 1980s – 1990s

While the decades from the 1920s to the 1970s were spent establishing the school counseling profession in Louisiana, the 1980s and 90s were dedicated to legitimizing the profession and helping education stakeholders understand the work of school counselors. According to notes received from P. Emerson (personal communication, 2005), the LDOE published a manual for school counselors in 1984. Bulletin 1730: Guidelines and Procedures for the Design of Developmental Guidance and Counseling Programs in Louisiana Schools, was developed by a steering committee appointed by the Bureau of Student Services of the LDOE (P. Emerson, personal communication, 2005). The guidelines and procedures included a school counseling job description, appropriate activities for school counselors to use with students, and details for parishes to develop and implement a three-year plan for school counseling (P. Emerson, personal communication, 2005).

In 1991, the Louisiana Legislature mandated elementary school counselors for all students in grades K-6 at one counselor ratio for every 400 students (La. Admin. Code tit. 28, CXVI §3005). Unfortunately, they did not include funding for the law (La. Admin. Code tit. 28, CXVI §3005). Three years later, Louisiana Legislative Act 45 (1994) of the Louisiana Legislature updated the definition of school counseling and clarified the roles and responsibilities of Louisiana school counselors. The definition also provided examples of inappropriate activities for school counselors such as clerical tasks, administration of discipline, and substitute teaching (La. Admin. Code tit. 28, CXVI §3002).

In 1996, school counselors' certification requirements changed, increasing the required credit hours from 21 to 24 in specific content areas and consolidating certification

from elementary and secondary into one level for K-12 (P. Emerson, personal communication, October 21, 1996). Prospective school counselors were given until 2001 to meet the increased certification requirements (E. Perez, personal communication, June 12, 1997). In 1997, the Louisiana Legislature enacted Senate Concurrent Resolution No, 123 which directed BESE to survey public schools about how school counselors and social workers spend their time and if there was a need to increase the number of school counselors and social workers (1997, SCR 123). The report found that 85% of counselors and social workers provided counseling services as required by law; however, 88% of school systems reported a need for additional counselors and social workers (P. Emerson, personal communication, 2005). A recommendation was made by BESE and the LDOE for the legislature to appropriate funding to hire more counselors and social workers; however, due to the expense, it was recommended this be accomplished over several years (P. Emerson, personal communication, 2005). During the same Legislative Session, the Career Options Law (<1997> La. Act. 1124) was passed. The Career Option law required every student to develop a five-year educational plan in collaboration with their family and school counselor (<1997> La. Act. 1124).

Following the publication of the American School Counselor Association's National Standards for School Counseling Programs (ASCA, 1997), the LDOE released the Louisiana School Counseling Model (1998). The mission was "to develop rigorous and challenging academic standards that will enable all Louisiana students to become lifelong learners and productive citizens for the 21st Century" (Louisiana Department of Education, 1998, p. ii). It included student content standards focused on academic and career planning and incorporated components of the Career Options Law (Louisiana Department of Education, 1998). The Louisiana School Counseling Model (1998) defined the term school counselor, provided BESE policies related to school counseling, the ASCA Ethical Standards, a glossary of school counseling terms, and many resources for Louisiana school counselors (Louisiana Department of Education, 1998). The model was designed to meet diverse learners' needs, including ethnically and culturally diverse students, students with special needs, English language learners, and gifted and talented students (Louisiana Department of Education, 1998).

By 1999, there had been another change to certification requirements. The new requirements included a master's degree in Guidance and Counseling from a regionally accredited college or university, three years of teaching experience, or for secondary school counselors, two years of teaching experience and one year of "accumulated occupational experience, and a passing score on the National Teacher's Exam (NTE) core battery and a specialty teaching area (Lum, 1999).

A Blue-Ribbon Commission on Teacher Quality was convened in the 1999-2000 school year. The Commission's main task was to improve teacher and administrator quality in K-12 schools (Blue Ribbon Commission for Educational Excellence, 2003). The Commission's fourth recommendation, "Creation of Essential Conditions and Environments," included two priorities specific to school counseling programs (Blue Ribbon Commission for Educational Excellence, 2003). The first priority was a paperwork reduction for teachers, counselors, support staff, and administrators at the middle school level so that they could

concentrate on student achievement; the second was to change the role of school counselors through a redesign of the school counselor program in order to allow more time for academic, career, personal and social counseling and to hire administrative help for record-keeping and paperwork responsibilities (Blue Ribbon Commission for Educational Excellence, 2003).

The 2000s

Following the passage of the Career Options Law of the 1997 Louisiana Legislature, Senate Concurrent Resolution 48 of the 2000 Louisiana Legislative Session repeated a request for a survey of Louisiana school counseling programs by the BESE Board (2000, SCR 48). The resolution also requested the establishment of a study group to consider the results and make recommendations (2000, SCR 48). The survey was designed to establish (1) how many schools had a comprehensive school counseling program, (2) how school counselors and social workers were being utilized, (3) the percentage of time being spent in direct service to students, (4) to determine if new accountability programs had increased counselor workloads, and (5) if there was a need for more counselors and social workers (2000, SCR 48). The survey did not find evidence of consistent implementation of comprehensive school counseling programs. However, it did find that components of comprehensive school counseling programs were being delivered (P. Emerson, personal communication, 2005). Recommendations included the statewide implementation of a comprehensive school counseling model, adoption of a counseling curriculum, time allocations for the school counselor's workday, a data management system with appropriate training, clerical help, and more school counselors (P. Emerson, personal communication, 2005).

Governor Mike Foster created the Governor's Secondary School Redesign Committee in May 2000, which recommended that Louisiana's school counseling programs be improved based on national standards and serving every student (Louisiana Department of Education, 2002; P. Emerson, personal communication, 2005). In the 2000 – 2001 school year, the LDOE, the Louisiana Workforce Commission, the School-to-Work Office, and the Community and Technical College System provided a three-day professional development summer workshop for nine schools. The workshop was designed to support the planning and implementation of comprehensive school counseling programs and address the school counselor's role in the Career Options Law (Louisiana Department of Education, 2002; P. Emerson, personal communication, 2005). The program was expanded to include other schools in the summer of 2001, with a plan for the schools involved to serve as model programs for other schools across the state (Louisiana Department of Education, 2002; P. Emerson, personal communication, 2005). Also, in 2001, LSCA advocacy work led to legislation, filed by Senator Tom Schedler of St. Tammany and Tangipahoa parishes, that provided a $5,000 salary supplement for school counselors with National School Counselor Certification (NCSC; <2001> La. Act. 682). Finally, in the 2001 Louisiana Legislative Session, House Bill 369 was filed by Vermillion Parish State Representative Mickey Frith (2001, HB 369). The bill intended to amend and reenact Act 911 of the 1991 Legislature by reducing the counselor-student ratio from 1: 400 to 1: 200 (2001, HB 369). Unfortunately, this bill never made

it out of the House Appropriations Committee.

The following year, 2002, the Louisiana Model for Comprehensive Guidance and Counseling, a second iteration of the Louisiana counseling model, was released. The updated model provided answers to frequently asked questions about comprehensive guidance and counseling and instructions for planning, implementation, and maintenance (Louisiana Department of Education, 2002). In October of the same year, LSCA collaborated with Senator Schedler to request an opinion from Attorney General Richard Ieyoub on whether school districts were responsible for paying the salary supplement to qualified school counselors (P. Emerson, personal communication, 2005). On January 9, 2003, the Attorney General returned his opinion that there was no question that school boards were responsible for paying qualified counselors the supplement as required by ACT 682 (P. Emerson, personal communication, 2005). The law and the Attorney General opinion are still current today.

The High School Redesign Commission (HSRC), created in 2004 by Governor Kathleen Blanco, was given the task of making recommendations in redesigning high schools so students could graduate with skills to be successful in post-secondary education or work settings (Public Affairs Research Council of Louisiana, 2011). The HSRC recognized the importance of school counselors, and with the approval of BESE, created the Professional School Counseling Task Force in 2007 (Professional School Counseling Task Force, personal communication, November, 2007). The purpose of the task force was to develop recommendations for school counseling and help increase student achievement in Louisiana (Louisiana Department of Education, 2010). The task force, co-chaired by Penny Dastague, BESE member, and Mary Gugich, LDOE, was composed of certified school counselors (50%) and other stakeholders (50%; Professional School Counseling Task Force, personal communication, November, 2007). Two meetings were held, October 11, 2007, and November 1, 2007 (Professional School Counseling Task Force, personal communication, November, 2007). During these meetings key concerns were identified, and recommendations were made.

The HSRC surveyed principals in Louisiana, finding that approximately (1) 32% of a school counselor's time was spent in guidance/counseling, (2) 23% of their time was test coordination, (3) 16% was master schedule duties, (4) 16% was registration, and (5) 13% was other (Professional School Counseling Task Force, personal communication, November, 2007). Recommendations made by the Professional School Counseling Task Force that were supported by principals included (1) adding a school counselor to the HSRC (83% agree), (2) hiring a certified counselor at the LDOE (63% agree), and (3) providing an accountability measure for the school counseling program (55% agree; Professional School Counseling Task Force, personal communication, November, 2007). One recommendation that the principals did not widely support was the mandated implementation of the ASCA National Model (37% agree, 49% unsure, 13% disagree; Professional School Counseling Task Force, personal communication, November, 2007).

The LDOE supported two of the recommendations by hiring a certified school counselor who became a part of the High School Redesign Team and holding a statewide school counseling conference in Marksville, Louisiana, in December 2009. The conference included ASCA trainers providing

professional development on the ASCA National Model at no cost to participants except travel and lodging expenses (Louisiana Department of Education, 2010). The third edition of the Louisiana school counseling model, The Louisiana School Counseling Model: A Comprehensive Student Development Program (2010), was released, replacing the two earlier models. The new model provided support for local school districts to develop comprehensive school counseling programs that included creating individual graduation plans for students in grades 8-12 (Louisiana Department of Education, 2010).

According to the Public Affairs Research Council (2011), the LDOE continued to improve Louisiana students' education and researched the dropout rate between 2006 and 2010. In 2009, the state legislature set a goal for the state to reach an 80% cohort graduation rate by 2014; the graduation rate was 67% in 2010 (Public Affairs Research Council, 2011). The LDOE took a closer look at the data, aggregating, and disaggregating the numbers (Public Affairs Research Council, 2011). Similar to the findings reported by Cooley in 1925, the LDOE found two reasons students were dropping out, either they lacked skills and knowledge to succeed in the school system, or they dropped out due to boredom, a crisis in their life, or discipline issues (Public Affairs Research Council, 2011). The latter group became the target for improving graduation rates (Public Affairs Research Council, 2011).

2010- Present

The Blue-Ribbon Commission became the Blue Ribbon Commission for Educational Excellence in 2000-2001 and met annually, making additional school counseling recommendations in 2011 (Blue Ribbon Commission for Educational Excellence, 2011). The areas considered for change included counselor education, school counselor certification, and provision of services intended to improve college and career readiness for PK-16 students in Louisiana. Areas of concern included the cohort graduation rate, post-secondary enrollment rate, and industry-based certification attainment by high school students (Blue Ribbon Commission for Educational Excellence, 2011). The Commission made nine recommendations including (1) the adoption of a counseling model, (2) standards to be implemented in all Louisiana school districts, (3) a counselor to student ratio of 1:300, (4) roles of school counselors defined succinctly in policy, (5) professional development for school counselors and other members of the school community that was meaningful and reflective of the Louisiana School Counseling Model, (6) a tool for evaluating school counselors, (7) certification standards that included a standards-based curriculum, (8) a passing score on the Praxis Exam for Professional School Counselors, and (9) a renewal requirement that included continuing education (Blue Ribbon Commission for Educational Excellence, 2011).

The Professional School Counseling Task Force reconvened in 2013 to work toward three goals (1) to learn about a revision to diploma pathways, (2) to review feedback from a school counseling focus group on (a) the school counselor evaluation tool, (b) LA Connect an electronic system for creating individual graduation plans, and (c) the LDOE's creation of a School Counselor toolbox on the LDOE website, and (3) to draft revision to the school counselor evaluation tool (LDOE, personal communication, July 11, 2013).

Where is Louisiana now with the recommendations from the Blue Ribbon Commission for Educational

Excellence? In 2015, school counselor certification was changed, and renewal requirements were added. Current requirements include graduation from a CACREP accredited program, including six credit hours in school counseling courses, practicum, and internship in a school counseling setting, and a passing score on the PRAXIS in school guidance and counseling (La. Admin. Code tit. 28, CXXXI §405, 2020; La. Admin. Code tit. 28, CXXXI §659, 2020). Renewal requirements include either verification of licensure as a Louisiana Licensed Professional Counselor or 150 hours of continuing education over five years (La. Admin. Code tit. 28, CXXXI §405, 2020; La. Admin. Code tit. 28, CXXXI §659, 2020). LSCA worked closely with the LDOE, resulting in a counselor track at the LDOE Teacher Leader Summit in 2018 and 2019 and counselor-led presentations at the Jumpstart Conference. The Professional School Counseling Task Force created the Louisiana Counseling Performance Evaluation Rubric based on the Louisiana School Counseling Model: A Comprehensive Student Development Program (2010). Currently, the LDOE does not have a supervisor of counseling at the state level. The 2010 version of the Louisiana counseling model is the most recent state model, while ASCA has published a third edition of the national model in 2012 and the fourth edition in 2019 (ASCA, 2012; ASCA 2019). According to the U.S. Department of Education, National Center for Education Statistics (2019), Louisiana's current school counselor to student ratio is 1:441 (National Center for Education Statistics, 2019).

On March 22, 2020, Louisiana Governor John Bel Edwards issued a stay-at-home order due to the COVID-19 pandemic. As a result, schools closed, and the school year ended with attempts at remote learning and accommodations being made around promotion and graduation as the school year came to an end. Meanwhile, a second pandemic was gaining steam following the killing of several unarmed Black men and women, including Ahmaud Arbery, Breonna Taylor, and George Floyd, setting off protests around the country bringing attention to racial injustice. Undoubtedly, these issues will impact Louisiana students; education will need to continue to adjust to serve and meet students' needs and school counseling will likely be impacted as well. Continued policy changes are needed. Is this the time in history when the support will be provided for school counselors to put their training to use to help students overcome today's challenges and meet their academic, college and career, and social and emotional goals? Only time will tell.

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Challenges to Interdisciplinary Behavioral Health Training During a Pandemic: A Qualitative Self-Review

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This paper explores the new challenges that interdisciplinary health care training clinics have experienced for the respective disciplines of counseling and psychology amid the COVID-19 pandemic. Previous challenges among these disciplines has always included the differences in specialty areas, ethical codes; and practicum and internship requirements. This current qualitative self-review identified three emergent themes from a training/service delivery perspective: Cessation of In-person Training; Cessation of In-person Assessments and Therapy; and Certification Requirements for Telehealth. Each theme is discussed from both a benefit lens and a challenge lens considering a possible future time where these modifications may need to be adopted again.

Keywords: pandemic, COVID, training, interdisciplinary training

Interdisciplinary health care teams have evolved over the years and have provided models for how healthcare professionals can deliver not only beneficial healthcare, but also quality training that provides education blended with real world clinical interactions. These interdisciplinary teams can provide training to an array of professionals from different disciplines and offer coordinated services by an integrated team of professionals. These integrated teams are, at times, embedded at the heart of university health science center's training programs. These interdisciplinary training program experiences expose healthcare students to the roles of other healthcare providers, interprofessional collaboration, and breaks down barriers and stereotypes.

However, the COVID pandemic provided challenges and areas for growth for many university training programs, internship programs, healthcare systems, and government agencies. This required that many programs focus on discipline specific issues, such as university accreditation requirements, training requirements, and logistical nuances. Additionally, many systems had to reevaluate specific requirements for telehealth and related privacy laws. Then, programs could possibly reintegrate as an interdisciplinary team to move forward providing mental health care in a manner in which many had never done before.

The authors deliberately use the general terms of student, trainee, and intern interchangeably to recognize that individuals are a variety of educational levels during this unprecedented educational opportunity. These terms, therefore, represent the full range of all trainees including those who may be beginning their graduate field experience as a practicum student; interns, at the master's level or doctoral level; and post-graduate. Additionally, the authors recognized that while others use the terms multi- and interdisciplinary interchangeably, we are purposely using the term interdisciplinary to best represent the true meaning and intent of the integrative practice of mental health professionals, allied health professionals, medical professional, etc.

While there have always been challenges to interdisciplinary training, the purpose of

this qualitative self-review was to expand upon typical training challenges with a focus on behavioral health service delivery for the respective disciplines of counseling and psychology amid the COVID-19 pandemic. This new set of circumstances presented unique concerns and forced interdisciplinary problem solving to ensure a new best practice of interdisciplinary behavioral health services to best match the situation. This review attempts to bring the reader from the history and benefit of interdisciplinary training to what could be regarded as current best practices under these unprecedented circumstances for both the delivery and training of interdisciplinary health care services. Finally, this template for interdisciplinary training may find itself again useful should the community, nation, or world find itself in yet another unfortunate situation similar to the one that has recently occurred.

History and Benefit of Interdisciplinary Training

Interdisciplinary healthcare teams appear to have originated during World War II with the appearance of multidisciplinary medical and surgical teams (Baldwin, 2007). Previously, healthcare was only provided in what is now known as traditional disciplinary models where professionals simply worked alone without interaction or consultation with other disciplines. There is evidence that a similar style of teaming entered into the mental health practice in the United States because of the summative efforts from the Kennedy and Johnson presidential administrations. It was during that time when significant reforms de-institutionalized both the patient and stigma of mental health disease by transferring services to community based mental health teams. Eventually this notion of multidisciplinary teaming would find itself in educational circles as well with the 1975 passage of Public Law 94 – 142, the Education for All Handicapped Children Act, which required that a child must be evaluated by a multidisciplinary team in all areas of suspected disability and the evaluation must consist of more than one procedure for either planning or placement purposes. The term inter-disciplinary does not appear in this legislation until it became re-authorized in 1990.

While teaming may have been inevitable in hindsight, it certainly evolved slowly. In a seminal article, Stember (1991) posited three areas of arguments promoting the logic of interdisciplinary teaming. These areas were categorized as intellectual, practical, and pedagogical arguments. From the intellectual argument, it stands to reason that ideas in any discipline are enriched by theories, concepts, and methods from other disciplines. The practical argument for interdisciplinary practice forces all to admit that the problems of the world are not conveniently packaged according to professional disciplines. Finally, the pedagogical argument highlights how fragmented curricula does not facilitate learning that is representative of real world mental health practices.

While the terms multidisciplinary and interdisciplinary are often used interchangeably, teaming purists argued a sharp distinction. Stemper (1991) created the uniform terminology that is still referenced today describing the professional models across the continuum of service delivery. The most basic model of the continuum was intradisciplinary,

which has a professional only viewing a problem and solutions from their disciplinary perspective. The next level higher was defined as crossdisciplinary, which incorporated the viewing of another discipline from one's own discipline perspective. Pursuant to that level was multidisciplinary, which utilized the perspective of several disciplines on the same problem or concern. Higher yet was interdisciplinary which for the first time required the interaction and integration of the discipline perspectives to create a more holistic representation of the problem or concern. Finally, transdisciplinary sat atop this service delivery continuum, which theoretically unified all of the discipline perspectives such that the blending removed the clear identification of any single contribution from any individual discipline.

Building upon existing definitions, DeGraw et al. (1996) broadly defined interdisciplinary team training as the education and training of an array of professionals from different disciplines in the provision of coordinated services by an integrated team of professionals. The authors stressed the importance of conveying an understanding and appreciation of the unique perspectives, knowledge, skills, values, and purposes of each discipline represented on the team. Additionally, the over-arching goal was to learn how to work interdependently and collaboratively with other members of the team.

While there are many benefits to interdisciplinary training, there are, however some continued challenges. Gale (2012) identified various concerns regarding interdisciplinary training, specifically the different licensing boards with different policies and procedures; this became particularly challenging during the early days of the pandemic. Not surprisingly, there can be many inconsistencies between mental health disciplines and their related university training programs, licensing boards, etc. A major discrepancy is the different ethical codes that each discipline must follow. Additionally, training programs may begin and end at different times throughout the year, thus creating differing trainee turnover rates, which may be problematic for clinical care and training coordination.

Traditional Challenges for Interdisciplinary Training in Behavioral Health

When considering interdisciplinary clinical training, a site must consider the unique training needs of each discipline. For example, each discipline may have different lengths of their respective university programs, ethical codes, and liabilities. In this vein, the disciplines of psychology and counseling have different specialty areas, entry-level degrees, and finally, practicum and internship requirements. The next section will explore the different training requirements across these disciplines for both practicum and internship. While there are many similarities, there are also substantial differences.

Counseling

The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) provides standards for both Entry Level (master's degree) and Doctoral level programs (https://www.cacrep.org/for-programs/2016-cacrep-standards/). Interestingly, when compared to psychology, the master's degree is regarded

as the entry-level for practice whereby graduates are prepared in one of the eight specialty areas: Addiction Counseling; Career Counseling; Clinical Mental Health Counseling; Clinical Rehabilitation Counseling; College Counseling and Student Affairs; Marriage, Couple, and Family Counseling; School Counseling; and Rehabilitation Counseling. Doctoral-level graduates are prepared for counselor education, supervision, and practice. Therefore, for the purpose of this discussion, only the 2016 CACREP Standards for the Entry Level (master's degree) will be outlined since they address the entry-level for practice.

Regarding practica and internships, the 2016 CACREP Standards required that students complete supervised counseling practicum experiences that total a minimum of 100 clock hours and 600 hours, respectively, over a full academic term that is a minimum of 10 weeks. Supervision must occur weekly with a supervisor that averages one hour per week of individual and/or triadic supervision throughout the practicum by a counselor education program faculty member, a student supervisor who is under the supervision of a counselor education program faculty member, or a site supervisor who is working in consultation on a regular schedule with a counselor education program faculty member in accordance with the supervision agreement. Regardless of mental health discipline, the site supervisor must have knowledge of the program's expectations, requirements, and evaluation procedures for students; and relevant training in counseling supervision. Therefore, practicum students must participate in an average of 1.5 hours per week of group supervision on a regular schedule throughout the practicum. Group supervision must be provided by a counselor education program faculty member or a student supervisor who is under the supervision of a counselor education program faculty member.

Psychology

The American Psychology Association (APA) only provided standards of accreditation for doctoral level programs to what it defined as Health Service Psychology. More specifically, these only included the specialty areas of Clinical, Counseling, and School Psychology. As a result, other specialty programs, for example Cognitive, Developmental, Social, or Sport Psychology had no professional educational standards. Similarly, the APA has no accreditation standards for terminal master degree programs (APA, 2015). Therefore, for the purpose of this discussion, the current APA Standards of Accreditation for Health Service Psychology (2015) will be addressed.

The APA standards stressed that the programs must provide opportunities for all of their students to achieve and demonstrate each required profession-wide competency. Additionally, since science is at the core of health service psychology, programs must demonstrate that they rely on the current evidence-base when training students. Therefore, the programs must ensure that the specific practicum and internship sites allow for the competent demonstration of most, if not all of these following areas: Research; Ethical and Legal Standards; Individual and Cultural Diversity; Professional Values, Attitudes, and Behaviors; Communication and

Interpersonal Skills; Assessment; Intervention; Supervision; and Consultation and Interprofessional/Interdisciplinary Skills.

Regarding practicum, the APA Standards require that sites must include supervised experience working with diverse individuals with a variety of presenting problems, diagnoses, and issues. The purpose of practica was to develop the requisite knowledge and skills to demonstrate the competencies. According these APA Standards, the programs needed to provide individual training plans appropriate to the student's current skills and ability, to ensure that the student has attained the requisite levels of competency to apply for internship. While, internships require supervision by a licensed psychologist, practica supervision can be provided by any appropriately trained and credentialed individual. The APA standards failed to indicate any minimal level of hours to be attained during any singular practicum or totaling across all practica by a student.

Regarding internship, these same APA Standards dictated only that students complete a one-year full-time or two year part-time internship if the internship was also APA accredited. If the student completed a non-accredited internship, then the program must provide evidence demonstrating the quality and adequacy of the internship in terms of the following: The nature and appropriateness of the training activities; frequency and quality of supervision; credentials of the supervisors; how the internship evaluates the intern's performance; how interns demonstrate competency at the appropriate levels; documentation of the evaluation of the intern in its student files. Unlike practicum, internships that are accredited by the APA are recognized as meeting the Association of Psychology Postdoctoral and Internship Centers (APPIC) doctoral membership criteria. It is in these APPIC internship criteria that stipulate a minimum of 1500 documented hours that must be completed in no less than 9 months and no more than 24 months.

Results of Qualitative Self-Review: Emergent Themes from the Pandemic

The on-going monitoring of traditional intra- and interdisciplinary training requirements according to these respective accrediting bodies (i.e., CACREP and APA, respectively) provided a useful stepping-off point to sharply identify distinct themes brought forth by the pandemic to produce meaningful and ethical responses. Ironically, these emergent themes had with them both benefits and challenges. Therefore, the identified emergent themes from this qualitative self-review were the following: Cessation of In-person Training; Cessation of In-person Assessments and Therapy; and Certification Requirements for Telehealth. Each are now presented and then discussed with both a benefit lens and a challenge lens.

Cessation of In-person Training

Traditional CACREP accreditation addresses areas such as: institutional settings, program missions and objectives, content, experiences, advising, qualified faculty, evaluation processes, etc. As part of the counseling accreditation, students must participate in an approved practicum and internship training (requirements discussed above) that included the use of audio/video or live supervision of student's interactions with clients. Certain internships may include interdisciplinary

training, which Schmidt (2021) recommended embrace "opportunities for students to understand their roles on these teams, effectively describe and implement counseling services and uphold the culture of interdisciplinary care" (p. 45). Additionally, these interdisciplinary training sites often offered practicum and internship interactions that provided face to face in an approved setting prior to the pandemic.

However, in early 2020, the COVID-19 pandemic interrupted the traditional in-person training of many interdisciplinary sites that hosted practicum and internship students across the United States. The pandemic shutdown much of the United Stated in March 2020, many interdisciplinary and university training programs transitioned to remote learning and stopped all direct patient care training services until policies and procedures for telehealth could be explored or developed. Bell, et al (2020) recognized that there were several factors that must be considered by the university training programs to address internships during the pandemic, including: public interest (continued care), clinical training sites, university related issues (integrity of training), and individuals (trainees, faculty, and other's wellbeing). While considering these factors, Bell et al. noted that many training programs struggled to develop policies that respected accrediting bodies, institutional guidance, national, state and local regulations—many of which were not clearly defined or aligned in the early spring of 2020. Such example was CACREP's notation that flexibility may be necessary for programs while noting "the potential consequences for students in the long-term including credentialing, portability, and future employment" (CACREP, 2020). CACREP encouraged innovation and flexibility while being mindful of the Professional Practice section of the standards. Once programs developed appropriate policies and procedures, many programs then allowed continued remote learning and telehealth services at willing and appropriate clinical sites with approved site supervisors.

Benefits of telehealth training

While site supervisors were used to being onsite with their interns, telehealth and social distancing practices disallowed such face-to-face interactions for many site supervisors, much less a larger interdisciplinary team. Supervisors were faced with the legal, ethical and professional obligations to serve clients, while considering the practicality of such services. As Hames, et al. (2020) pointed out, many psychology training programs were forced to consider whether they would cease training or rapidly switch to telehealth due to state and local stay at home orders.

Telehealth benefits for students in training included access to supervisors and interdisciplinary teams with specialization, certifications, or clientele not previously available in their local community. Additionally, students who trained at interdisciplinary sites gained experiences such as: working within a team, integrating counseling theory into practice, exploring ethical dilemmas from a counseling perspective, and improved care (Schmidt, 2021). These interdisciplinary training programs also had greater ability to provide services outside of traditional business hours with reduced travel or commuting

times creating an increase in flexibility when offering telehealth services.

Additionally, students reported positive telesupervisory experiences (Tarlow et al., 2020). Their study surveyed a small sample of interns who transitioned to telehealth during the early stage of the pandemic and found in-person supervision had similar outcomes to telesupervision. Additionally, when exploring supervision satisfaction and the supervisory working alliance, there was little decrease in satisfaction. While this small sample cannot be generalized across all supervisory relationships, it does support future telesupervision education, training, and research.

Challenges to telehealth training

Supervisors are traditionally in person in the same clinic with their trainee, therefore able to observe body language, waiting room interactions, professionalism, etc. Over telehealth, the supervisor and/or interdisciplinary team are able to observe sessions, recordings, and participate in supervision, but may rarely see the trainee between sessions in the "office". However, some supervisors work in clinical settings that require "well-controlled clinic environment with on-site access to a supervisor" (Hames, et al., 2020). Other interdisciplinary training challenges included supervisors who may simply be uncomfortable allowing services in new and unfamiliar ways, whether due to physical location differences or new technology.

When the decision to provide interdisciplinary training, telehealth, and remote supervision was contemplated, a myriad of other issues also had to be considered. The supervisor and interdisciplinary training team must consider each student's ability to provide telehealth services on multiple levels: university requirements, telehealth training, competency, licensing board rules/regulations, and if liability insurance covers such services. These requirements may be similar for disciplines, but have unique university or professional requirements. Clinical sites were asked to review and agree to revised contracts or site agreements. Additionally, supervisors must contemplate how they would share or transfer both client/patient information as well as student evaluations—considering both HIPPA and FERPA considerations. Site staffing may have been revised and provided remotely to all professionals. Thus, considerations for confidentiality and privacy across multiple remote locations required additional attention previously not required.

In the spring of 2020, interns had varied experiences: some were nearing graduation with almost a full year of clinical experience; some were in beginning stages of practicum while others were exploring options for future practicum site with no clinical experience. Some interns were interested in interdisciplinary healthcare and telehealth services prior to the shutdown. Other university programs had students with no interdisciplinary education, much less training in telehealth. Universities worked with students to increase knowledge, skills, and exposure to telehealth. Some professional organizations sponsored low to no cost trainings for their members.

Overall, interns at interdisciplinary sites experienced a variety of challenges when not experiencing in person internship training. Interns may lack opportunities to join other clinical team member's sessions

(due to the planning required for telehealth), observations of other clinicians, and professional exchanges that typically happen in offices or agencies. In traditional in person internship programs, interns may have had opportunities to participate in spontaneous case consultations that now may not occur as frequently via telehealth. Schineider, et al. (2020) recommended that university-based training programs recognize interns' mental health, training needs, received support and desired support. Furthermore, Schineider, et al. recognized that interns might be especially challenged by the lack of communication from university programs and internship sites. Therefore, strongly recommended communication that is regular, that provides updates, discussed policy and procedure changes, and incorporates feedback.

Certification Requirements for Telehealth

Different states required different trainings for telehealth certification prior to the pandemic. For example, in the State of Louisiana, counselors were required nine hours of live telehealth training, while psychologist were required to have none. However, some counselors did not hold such trainings or certification prior to the onset of the pandemic since they provided services in a traditional in person format. Therefore, it was possible that the supervisors within these interdisciplinary teams were attempting to gain telehealth education to provide mental health services within the scope of their individual practice. Psychologists on the other hand were advised that telehealth (i.e., telepsychology) is not a separate specialty and were only encouraged to maintain competence in this area via appropriate continuing education.

Quickly, the State of Louisiana rescinded the nine hours of live telehealth training requirements for Licensed Professional Counselors to practice telehealth in the spring of 2020 due to the pandemic. This allowed counselors to practice without the previous required live nine hours of telehealth training, which most would have been unable to acquire due to social distancing requirements across the state. However, clients were then without mental health services in some instances for two to three weeks while clinical sites worked to provide appropriate, legal, and ethical telehealth services. Students at some universities disallowed internship training until policies and procedures could be established. CACREP released guidance statements and amendments to the traditional training requirements during the spring semester of 2020. Such movements allowed many counselors to begin providing clinical services via telehealth, telesupervision, and participate in remote trainings. However, this left interdisciplinary sites with the extra step of then working through policies and procedures that would again allow for interdisciplinary education, experiences, and collaboration via telehealth.

Cessation of In-person Assessments and Therapy

The rapid growth of telehealth availability during the pandemic permitted patients to access to a wider pool of clinicians, as patients were able to see interdisciplinary teams outside of their hometown. Telehealth may have offered new opportunities for those in rural areas to access a wider pool of providers, including

those certified in evidenced based treatments for the client's presenting issue. While these interdisciplinary teams offering telehealth services encountered some barriers, many modifications or mediations have been recommended.

When these teams offered evidenced based treatments that required access to protocol materials, Ralston, et al (2020) believed that some barriers, such as lack of access to protocol materials, could be mediated. For example, Ralston, et al., recommended that clinicians consider utilizing videoconferencing with shared screens, mail, or securely emailed materials. Many electronic medical record sites such as Therapy Notes or Simple Practice allowed uploading of documents for patient access. Additionally, regulations and telehealth certification requirements were rescinded by professional organizations and licensing boards to allow for continued services with a reduction of harm model in mind. This allowed telehealth platforms to be utilized that may not have previously met industry standards.

Mental health professionals were also faced with utilizing assessments in a modified fashion. Hames (2020) cautioned that trainees should be trained in methods that are secure and standardized before allowing modifications. If modifications are necessary, the supervisor should ensure that the trainee is made aware of the rationalization, legal, and ethical standards surrounding such practices (Hames, 2020). Additionally, Ralston, et al. (2020) proposed that supervisors promote flexibility within fidelity. They acknowledged that adjusting traditionally manualized treatment protocols for telehealth without modifying to the point of becoming ineffective or compromising treatment fidelity was important during the pandemic. Ralston, et al. acknowledged that flexibility and fidelity allows clients in rural areas access to evidence-based treatments. However, one must still consider how these modifications would be made while still training and/or educating interns.

Conclusion

The COVID pandemic brought many challenges to the field of mental healthcare, but also benefits. Meeting challenges with benefits, many interdisciplinary training programs rose to meet the needs of their populations. University training programs quickly moved to remote education and faculty supervision while considering their professional standards (APA, CACREP, etc.) and the legal requirements of FERPA and HIPPA. Site supervisors explored telehealth training, telehealth supervision, electronic medical records, telehealth platforms, and possible modifications to treatment or assessment protocols. Sites were also challenged to consider how they would provide supervision and staffing across disciplines, exploring access to HIPPA protected medical records, confidential video conferencing platforms, etc. Additionally, licensing boards, state and federal regulating bodies, and specialized certification programs were tasked with providing guidance on best practices during an unprecedented time.

Trainees at multiple levels were exposed to telehealth and remote learning at the same time as many of their faculty and site supervisors. This was a unique situation for many interns to find themselves. Trainees reported a multitude of varied experiences, satisfaction with supervision, and interdisciplinary training.

However, many programs continued to offer education, supervision, and patient care.

Pandemic research outcomes continue on an array of levels including: interdisciplinary training, supervision, remote learning, telehealth, and telesupervision. As research guides practice in a variety of clinical sittings, training should be no different. University and clinical training programs must assess what worked and areas of growth during remote learning and training. Moving forward, university training programs should preemptively incorporate telehealth training; expose graduate students to remote interdisciplinary trainings, and clinical supervision.

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The Theory-Application Gap in Non-Clinical Settings

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Theoretical orientation is used to assist clinicians in understanding client behavior, treatment plan development, and evaluating treatment progress. Though the Council for Accreditation of Counseling and Related Educational Programs (CACREP) places a great emphasis on the importance of using theory in counseling, there is significant research that points to the existence of a gap between counseling theory and the application of theory within the therapeutic process (Murray, 2009; Proctor, 2004). This paper reviewed the barriers that counselors face when applying theory in community mental health settings, schools, medical settings, and, correctional facilities. The literature suggested that there are often distractions in community settings, such as video games and television (Lawson, 2005). As a result, clinicians may experience challenges establishing healthy boundaries (Lawson, 2005). School counselors play a multifaceted role in their profession which can lead to time limitations (Gingerich & Wabeke, 2001). In medical settings, clinicians should assess client needs, medical personnel environment, and any special conditions that the client may have (Karademas, 2013). Considering the climate of correctional facilities, counseling providers are faced with the possibility of clients experiencing role confusion defined as a lack of understanding of the true nature of the therapeutic alliance (Haag, 2006). It is important that researchers and clinicians examine the specific contextual challenges associated with non-clinical settings to better understand the barriers to theory application that counselors face in these settings. Further research focused on other non-clinical settings besides schools, hospitals, prisons, and homes would be a valuable addition to the literature.

In the field of counseling, the term theoretical orientation most commonly refers to a particular framework that students, counselors, and researchers can use to conceptualize client needs (Polanski & McLennan, 1995). A theoretical orientation can help clinicians understand client behavior, create treatment plans, and evaluate progress in treatment. Essentially, a theoretical foundation acts as a sort of roadmap to follow when completing the essential parts of effective treatment including case conceptualization and treatment planning. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) places such importance on theory in counseling that it includes the teaching of theories and models of counseling as a foundational component in its education standards for graduate-level counseling students (CACREP, 2018). In addition to clients benefitting from the effective treatment of a theory-driven process, beginning counselors who practice from a specific theoretical orientation are also more likely to report feelings of competence and confidence than their non-theory oriented peers (Consoli & Jester, 2005).

Despite these standards and benefits that suggest the importance of theory in the practice of clinical counseling, there is significant research that points to the existence of a gap between counseling theory and the application of theory within the therapeutic process (Murray, 2009; Proctor, 2004). This gap is concerning given the fact that a large majority of mental health professionals identify as eclectic or integrative meaning that a majority of counselors do not rely on one particular theory to guide their practice (Consoli & Jester, 2005). This theory-application gap is also concerning when considering the implication that counseling as a field is built on the actual application of theory. If such a chasm exists between educational standards and the actual practice of counseling, it suggests there is an issue

with the dissemination of theory or that a number of counselors are potentially practicing independent of any standardized practice. At best, it can mean beginning counselors might struggle with creating a cohesive framework for treatment. At worst, theory applied incorrectly without standards can be harmful to clients (Halbur & Halbur, 2011).

This gap between the teaching and application of theory is especially evident in non-clinical settings (Murray, 2009; Rowell, 2008; Stahmer, 2007). As a number of non-clinical settings lack theoretical guidelines specific to those settings (Hammond & Czyszczon, 2013), it becomes paramount for professionals in non-clinical settings to have a theoretical foundation on which to build their practice. Potharst, Baartmans, and Bögels defined non-clinical settings as schools and clients' homes for the purpose of their 2018 study whereas Critchfield and Benjamin (2008) defined non-clinical settings as inpatient psychiatric facilities in comparison to the clinical setting of college counseling centers. Whereas these authors chose to define non-clinical settings by their relation to a previously defined clinical setting, other researchers chose to define similarly non-clinical community settings as "non-traditional" such as Knapp and Slattery (2004) and Maxfield and Segal (2008). This paper will use the term non-clinical to describe these settings. Although a number of settings could potentially be described as non-clinical, this paper focuses on four specialized settings including schools, medical settings, clients' homes, and correctional facilities as defined by Gladding and Newsome (2010). The paper will review the barriers that counselors face when applying theory in these four specific non-clinical settings and will explore potential solutions to closing the theory-application gap in these settings.

Literature Review

A theoretical orientation can help clinicians understand client behavior, create treatment plans, and evaluate progress in treatment. However, the literature suggests that the setting for this treatment can be a factor in the gap between theory and practice, specifically clinical versus non-clinical settings (Murray, 2009; Rowell, 2008).

Explanations for the Theory-Application Gap in Non-Clinical Settings

When trying to understand this theory-application gap in the literature, it is paramount to first identify possible causes or explanations for this gap. Brosman, in his 1990 meta-analysis, typified his explanation for this theory-application gap with the simple statement "home-based therapy is not merely office-based therapy transplanted to different soil" (p. 4). In his research, Brosman noted that the main deterrent in effective treatment, related to the effective application of theory in a home-based setting, was role-confusion. He gave the example of the client confusing the role of a therapist with that of law enforcement or child protective services. Fernando (2008) echoed this explanation for the gap in theory to application in her narrative ethnography. Fernando spoke on how the role of the clinician can be confused without the literal walls of the clinical office confining and defining the legitimacy of the counselor in an atypical setting. Fernando went on to suggest that both the counselor and the client might hold fantasies about the roles of the counselor where the client might hold expectations for the counselor to provide tangible assistance and the counselor might hold expectations of playing the hero or the savior. These perspectives are important when examining the narratives

of counselors in non-clinical settings so that the research might begin to see patterns within these narratives. Whereas Brosman and Fernando discussed this role confusion in a community setting, other researchers, such as Astramovich et al. (2010) and Rowell (2008), focused on role-confusion as an explanation for the theory-application gap in schools noting how administrators and other stakeholders will often ask school counselors to fill additional roles such as that of a disciplinarian, teacher, or assessor.

Murray (2009), on the other hand, offered the theory of the Diffusion of Innovation as an additional explanation for this gap in theory and practice in his qualitative research. In this study, Murray argued that as with technological advancement, counselors would only integrate new theories or innovations under certain circumstances such as the advantages of using a theory, how understandable the theory is, how compatible the theory is with the counselor's values, and how well the counselor can connect changes to results. The diffusion theory provides a model for researchers, including those in this proposed study, to understand at what point in the model the theory-application gap occurs. Kazdin (2008) made similar arguments stating that although psychologists needed to use evidence-based treatments, more qualitative research was needed to understand the mechanisms of change as it relates to the adoption of new practices. Kazdin's suggestions provide a justification for further qualitative research, such as this study, that seeks to examine how theory is applied over time.

Possibly the defining cause of this theory-application gap in non-clinical settings, the role of managed care must not be overlooked. Sanchez and Turner (2003) reviewed how the managed care system in the United States had influenced the practice of psychology and found that managed care appeared to have a negative effect on quality of treatment. Most relevant to the use of theory, the authors found that therapists who work within a managed care system felt compelled to focus on superficial issues instead of addressing underlying issues to the presenting problems suggesting that therapists working within this model chose particular theories to fit this healthcare system. Evans et. al, (2002) had previously explored the topic of practitioner's attitudes towards brief approaches to counseling and found that counselors in clinical settings, such as private practice, were more favorable towards brief interventions than those in what they defined as nontraditional settings. However, this study did not offer a clear answer on the actual application of these brief approaches, but, rather, focused solely on the attitudes of counselors on these approaches and did not note whether or not these counselors actually used these brief approaches in their practice. Czyszczon (2014) echoed the findings of Sanchez and Turner in his qualitative research that focused on the experiences of home-based counselors, noting that managed care systems preferred quick, inexpensive treatment options that aligned with particular counseling theories. More troubling, Birch and Davis (1984) were some of the first researchers to point out an apparent trend in insurances allowing those without training in the field of counseling to provide similar services, indicating that many practitioners do not have the training or education to practice from any one particular theoretical lens. Hammond and Czyszczon (2013) referred to these mental health professionals as "paraprofessionals" and argued for more standardization, including standardized theories, in non-

clinical settings such as this study hopes to explore.

Barriers to Applying Theory in Specific Non-Clinical Settings

In addition to the listed potential causes of the theory-application gap, there are also barriers to applying theory that are specific to non-clinical settings such as schools, hospitals, prisons, and the community. For instance, the American School Counselor Association (2016) promoted the role of school counselors as academic support staff meaning school counselors are moving away from providing one-on-one individual counseling for students. Astramovich et. al. (2007) noted that school counselors face several barriers to providing effective treatment including the expectation for school counselors to complete administrative tasks and the need for time-sensitive interventions that are able to be used within the time constraints of a school year. As far as solutions to these challenges, several studies have examined the use of specific counseling theories within schools. Chibbaro and Camacho (2011) spoke on the benefits of creative counseling within schools which they argued allowed students to express difficult emotions and might be especially helpful with students with cultural differences from the overarching culture of the school. On the other hand, Gingerich and Wabeke (2001) suggested that a solution-focused approach was the most helpful for school counselors, specifically those working with students with diagnosed behavioral disorders. Lastly, Ruffolo and Fischer (2009) supported the use of cognitive-behavioral therapy in schools due to the large amount of empirical evidence in its favor in clinical settings.

As with counselors in school settings, counselors in hospitals or medical facilities face their own unique challenges when it comes to implementing theory. Edwards and Patterson's 2006 research focused on the supervision of therapists-in-training within a medical setting and identified the importance of setting and the understanding of medical culture. Focusing on theory application in a medical setting, Karademas (2013) noted that counseling health psychologists often have to balance multiple considerations when choosing a theory such as patient needs, the medical environment, and the perspectives of a multi-disciplined treatment team. Karademas also pointed out that medical patients are often in need of short-term and solution-focused interventions that can accommodate their physical health recovery.

Because counselors in schools and medical settings might work with clients who choose to seek out services, counselors in prisons are highly likely to work with clients who have been mandated to receive services as part of their sentence or recovery. As role confusion is a factor in other non-clinical settings, Elliot and Shrink (2009) specified that counselors in correctional facilities might be especially confused about their role since American society at large appeared to send conflicting messages about the role of prisons i.e. to punish or to reform. Fruehwald's research (2003) suggested that counselors in prisons face additional safety issues as the suicide rate in prisons was approximately three times higher than that of populations in other non-clinical settings. De Jong (2001) argued that since most counseling theories were created for clients who chose to seek out services, there should be a separate theory or theories for working with mandated inmates in correctional facilities. From an existential theoretical orientation, Yalom (1980) argued that people who are imprisoned might contend with the four

givens of existential therapy: freedom and associated responsibility, death, isolation, and meaninglessness.

Lastly, counselors in community settings face challenges to applying theory due to the volatile nature of providing services in clients' homes. Fuller (2004) contended that home-based counselors might be prone to role confusion as the clients might confuse the professional with a visitor or guest. Lawson (2005), on the other hand, suggested that counselors in this setting might face role confusion in the context of the client confusing the counselor with law enforcement or child protective services. As with correctional facilities, Maxfield and Segal (2008) noted in their case study that counselors in home-based settings might also have to take into account safety issues when applying theory due to the unstructured and possibly safety issues in home-based work. Macchi and O'Connor (2010) discussed the use of theory in community settings and suggested that counselors should choose a theoretical orientation that allows for the counselor to take in contextual information about the client's home to inform their treatment.

As evident in the literature, there appears to be a consensus that counselors in non-clinical settings must choose theories that are time-sensitive and flexible to accommodate for a changing environment. However, researchers and clinicians alike could benefit from a clearer understanding of how theory is currently applied in these settings while taking these restraints into account. As discussed in this literature review, professional counselors in non-clinical settings face multiple barriers to applying theory compared to their clinically-based peers (Karademas, 2013; Astramovich et. al., 2007). This paper will review specific barriers counselors face in non-clinical settings to applying theory and will discuss potential solutions to lessen this theory-application gap.

Challenges to Applying Theory in Community Mental Health

Home-based counseling, or community mental health counseling to which this modality is often referred, is usually associated with the practice of the counselor meeting the client in the client's home or in a community setting instead of the client traveling to meet the counselor in an office. Home-based services provide several benefits including allowing clients with few financial resources, such as transportation or childcare or who live in rural areas, to receive services (Hammond & Czyszczon, 2013). These services can send the message to the clients that the counselor is going the extra mile and can even hasten the building of the therapeutic relationship (Macchi & O'Connor, 2010; Woodford et al., 2006). Community counseling was created with the purpose of having fewer restrictions to meet the needs of clients with the highest needs (Gladding & Newsome, 2010). However, fewer restrictions can also be understood as fewer boundaries around the role of the home-based counselor and can lead to possible confusion about the standardized use of theory in community mental health. For example, agencies who provide home-based services are likely to hire paraprofessionals who lack formal training in counseling theory (Hammond & Czyszczon, 2013). The importance of proper training in theory is evident in research that indicates states whose agencies primarily hired untrained paraprofessionals ended up paying more in the long-term for mental health care due to lack of qualified care for clients with more severe mental health needs (Gladding & Newsome, 2010). Home-based counselors also face the barrier of working with multi-

challenged clients which can make choosing which issues to focus on first difficult from a theoretical perspective (Lawson, 2005). Additionally, the home environment itself has a number of distractions such as television, children, and pets, not to mention safety issues in the home that might distract a counselor from applying theory in an effective manner.

Integration

When considering these challenges associated with applying theory in a client's home, there are several recommendations for the beginning counselor. First, adopting a theory that takes a systemic approach can allow the counselor to understand how the client or family operates within the larger environmental context of the home or the community (Lawson, 2005). Furthermore, the home-based counselor can work to reframe distractions in the home as important contextual information that can inform treatment (Macchi and O'Connor, 2010). For example, the feminist counselor might work to empower clients to set their own boundaries around session time by asking visitors to come another time or the person-centered counselor might explore incongruences between the client's verbal messages and contextual information in the home. Lastly, closing the theory-application gap might require a more systemic change on the part of managed care systems where insurances might require additional education standards to include theories and community agencies work to hire professionals with extensive training in theory such as those who graduate from CACREP accredited graduate programs.

Challenges to Applying Theory in Schools

School counselors play a multifaceted role in their profession, including both administrative and therapeutic responsibilities. Considering both the administrative tasks of a school counselor in addition to student coursework, there is limited time obtainable for therapeutic intervention. Interventions should also be suitable for different age groups (i.e. elementary, middle school, and high school).

Integration

Many school counselors utilize time efficient theoretical approaches to best accommodate their students. A popular theory seen in school settings is solution-focused therapy (Gingerich & Wabeke,2001). Solution focused therapy is a therapeutic conversation that is characterized by the dominance of identifying a solution, rather than prolonged focus on the problem at hand. In school counseling, students are typically mandated to participate in counseling (Gingerich & Wabeke,2001. Solution focused theory suggests that it is most important to briefly discuss student complaints and then allow he or she to develop an idea of what is necessary for change (Gingerich & Wabeke,2001).

When considering elementary aged students, it may be difficult for them to communicate their feelings (Chibbaro, & Camacho, 2011). Creative counseling encourages clients to visually express and release their emotions. It consists of, but is not limited to art, music, dance/movement, drama, poetry, and creative writing (Chibbaro, & Camacho, 2011). Therapists often use creative counseling when children find it embarrassing to talk about

traumatic topics of concerns, such as abuse or neglect (Chibbaro, & Camacho, 2011). It can also be helpful for students who have cultural or language barriers.

Cognitive Behavioral Therapy assists children and adolescents work through thoughts, feelings and behaviors (Ruffolo & Fischer, 2009). School counselors sometimes use CBT interventions for adolescents (ages 11–18) with anxiety and depression. Schools that implement and adapt evidence-based practices need to have administrative supports (Ruffolo & Fischer, 2009).

Challenges to Applying Theory in Medical Settings

In medical settings, counseling psychologists have to consider patient needs, medical personnel environment, and any special conditions that they client may have. They should also be familiar with the diversity of the client's need (i.e. both psychological and medical) (Karademas, 2013). All levels of a patients' care are deemed as equally important (Karademas, 2013).

Integration

To achieve intervention goals, counseling health psychologists may choose from different intervention techniques, such as: individual and group counseling, brief therapies, crisis intervention, stress management, motivational interview, guided imagery, behavior analysis and modification, cognitive restructuring, etc. (Karademas, 2013). The majority of these techniques and strategies are based on the cognitive behavioral model (Karademas, 2013). Techniques can be utilized in group, individual, and crisis situations (Karademas, 2013).

Challenges to Applying Theory in Correctional Facilities

Prisons, or correctional facilities, provide counselors in these settings with their own unique challenges to applying theory effectively. As with other non-clinical settings, role confusion can play a major part in the theory-application gap in corrections. For example, counselors working in corrections can have multiple roles within the prison system including assessment, treatment, crisis response, administration, and consultation (Haag, 2006). In fact, society in general appears to vacillate on whether prison is for reform or punishment (Elliot & Shrink, 2009). There is perhaps no greater illustration of this conflicted thinking than the Nutraloaf. The Nutraloaf is a food made of ground up leftovers that facilities use as both a food source and a form of behavior deterrent for inmates who have broken facility rules (Barkclay, 2014). Following this logic, there is evidence that society also questions whether or not inmates are "entitled" to grief groups because it is thought to be in direct conflict with the idea that prison serves as punishment (Gladding & Newsome, 2010, p. 345). These contradicting messages can make it difficult for the beginning counselor to identify and advocate for their role using their theoretical foundation within the prison system. The high suicidality rate in corrections also makes it difficult for counselors to use theory effectively due to the high-stress nature of the work (Fruehwald, 2003). Lastly, limited privacy due to the nature of corrections work and limited access to furniture or rooms with carpeting can make it difficult for counselors to mirror a warm and welcoming clinical environment where most major theories were created (Gladding & Newsome, 2010).

Integration

When considering potential solutions to the theory-application gap in correctional facilities, it is important for counselors to first work to understand the particular culture that is specific to that correctional facility (Kupersanin, 2001). For this reason, a systemic or multicultural approach might be appropriate to use in this setting. A counselor practicing from an existential approach might note that inmates must deal with the four givens on a regular basis to include freedom and associated responsibility, death, isolation, and meaninglessness (Yalom, 1980). One issue with finding a theory that fits within the context of corrections is that many practitioners might assume that counseling in corrections has few differences with counseling clients in other settings due to lack of a standardized model. Some researchers argue that a new theory entirely is needed to work effectively with mandated clients, specifically those within a corrections context (De Jong, 2001).

Summary

Practicing from a theoretical orientation allows counselors to provide effective, standardized care, making the gap in theory to clinical application concerning for both practitioners and educators. There is evidence to suggest that this gap is especially prominent in non-clinical settings such as schools, prisons, hospitals, and client's homes (Murray, 2009; Rowell, 2008; Stahmer, 2007). Whether the cause of this larger theory-application gap lies with managed care organizations (Evans, Valadez, Burns,& Rodriguez, 2002) or role confusion (Brosman, 1990), researchers and clinicians should examine the specific contextual challenges associated with non-clinical settings to better understand the barriers to theory application that counselors face in these settings. Further research focused on other non-clinical settings besides schools, hospitals, prisons, and homes would be a valuable addition to the literature.

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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 CE Clock Hours. Once scored, you will receive a certificate verifying **2.5 Continuing Education Clock Hours**.

Incorporating the Reproductive Story Intervention for Men Having Experienced Pregnancy Loss

1. What percentage of all clinically recognized pregnancies end in miscarriage?
    A. 25%
    B. 15%
    C. 10%
    D. 5%

2. Who has a reproductive story?
    A. Parents
    B. Those who experienced a pregnancy loss
    C. Everyone
    D. Children

3. The reproductive story can help men with pregnancy loss by
    A. Focusing on their role as a partner and helping them shoulder the grief of their partner associated with the pregnancy loss
    B. Focusing on them as an individual and creating a space for them to explore their grief associated with the pregnancy loss
    C. Focusing on them as a couple and exploring how the pregnancy loss has affected their relationship
    D. Focusing on their detachment from their partner and loss of independence.

Addressing Climate Trauma among Adolescents: Process-Oriented Group Therapy as a Way Forward

4. Group therapy is an indicated treatment for working with the mental health implications of climate change because it provides which of the following:
    A. Creates feelings of distress and anxiety
    B. Provides clear answers on how to solve the climate crisis
    C. Works to make the climate change threat feel less abstract and more embodied and phenomenological
    D. All of the Above

5. Why is it important to address climate trauma among adolescents?
    A. The desperate need to develop humanity's capacity to meaningfully and honestly engage with the reality of climate change
    B. The disproportionate impacts of climate trauma on this population
    C. The role this generation will play in managing climate change impacts in the future
    D. All of the above

6. In addition to alignment with Yalom's therapeutic factors, process-oriented group therapy can benefit adolescents coping with climate trauma due to:
    A. The group's emphasis on the here-and-now approach
    B. The group's ability to get others to take part in pro-environmental efforts
    C. The opportunity for group facilitators to ameliorate participants' guilt around climate change
    D. None of the above.

History of School Counseling in Louisiana

7. The first known career day was held at:
    A. Alcée Fortier High School
    B. Hahnville High School
    C. Istrouma High School
    D. Ponchatoula High School

8. The founder of Louisiana's vocational guidance movement was:
    A. Emma Pritchard Cooley
    B. Frank Parsons
    C. Joseph Gwinn
    D. Meyer Bloomfield

Challenges to Interdisciplinary Behavioral Health Training During a Pandemic: A Qualitative Self-Review

9. Which of the following terms describes the theoretical best model of service delivery?
    A. Intradisciplinary
    B. Crossdisciplinary
    C. Interdisciplinary
    D. Transdisciplinary

10. Which of the following is viewed as a challenge to telehealth services?
    A. HIPPA and FERPA considerations
    B. Increased access to supervisors.
    C. Services can be offered outside of the traditional business hours
    D. Transportation to and from the service appointment

Credit Verification Form for Licensed Professional Counselors

The Louisiana Counseling Association awards **2.5 Continuing Education Clock Hours** 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 CE Clock Hours, LCA members may complete the form below and mail it, along with **$10 (non-LCA members, $25)** and your completed test questions, to the following address:

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

The Louisiana Counseling Association has been approved by NBCC as an Approved Continuing Education Provider, ACEP #2019. Programs that do not qualify for NBCC credit are clearly identified. LCA is soley responsible for all aspects of the program.

I verify that I have read the entire **Winter 2020-21** 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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Mailing Address

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Street

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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. Articles should be scholary; be based on existing literature; and include implications for practice. Manuscripts should fall into one of the following categories, although other kinds of submissions may be appropriate.

MANUSCRIPT CATEGORIES

The following categories describe the nature of submitted manuscripts. These categories were adapted from the American Counseling Association's *Journal of Counseling and Development (JCD).*

1. **Conceptual/ Theory.** New theoretical perspectives may be presented concerning a particular counseling issue, or existing bodies of knowledge may be integrated in innovative ways. All theoretical pieces must include implications for counseling practice, and when appropriate, implications for public policy related to the counseling profession.

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. Authors are expected to discuss the clinical significance of the results.

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 (7th ed.)*. The APA *Publication Manual* sets forth all guidelines concerning manuscript format, abstract, citations and references, tables and figures, graphs, illustrations, and drawings. *(following JCD guidelines)*

Title Page: The first page of the manuscript should be masked and only contain the title of the manuscript.*

> *Note. Prepare a separate, supplemental file labeled "Title Page" and email in addition to the blinded manuscript. This title page document should contain the article title, the names and affiliations of all coauthors, author notes or acknowledgements, and complete contact information of the corresponding author who will review page proofs (including complete mailing address and email) in the following format:
>
> > Author(s) Name only (i.e., no degrees or position titles listed), Department Name, University Name, at City (if applicable). Author Name is now at Department Name, University Name, at City (if changed from above listing). Correspondence concerning this article should be addressed to Author Name, full mailing address (including street or PO Box), City, State (using postal abbreviation), zip code (email: name@name.edu).

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