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**Editors**

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# Editorial

## Louisiana School Counselors' Voices Matter: Gathering Input for Updating the American School Counselor Association's Code of Ethics

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School counselors must follow ethical guidelines to make informed decisions that are in the best interest of their student clients. To assist in achieving these goals, the American School Counselor Association (ASCA) made over 40 new revisions in the Code of Ethics in 2010 (Huey, 2011), and will be revised again and published in July of 2016. The purpose of this study is to highlight what current school counseling professionals believe will be the areas to be addressed by the new revisions to the ASCA Code of Ethics. A survey was disseminated and results are reported. Louisiana school counselors had valuable input into the draft, much of which was included in the updated 2016 Code of Ethics.

*Keywords:* school counseling, ethics, ASCA, survey research

Every profession has an ethical code that sets guidelines for professional behavior within that profession. Like lawyers and doctors, counselors must follow ethical guidelines to make informed decisions that are in the best interest of their clients. The American Personnel and Guidance Association was established in 1952 and has always had a professional code to guide its members; known subsequently as AACD (American Association of Counseling & Development), and now known as the American Counseling Association (ACA). These codes have been revised and updated regularly to reflect changes in the field in years 1955, 1961, 1974, 1988, 1995, 2005 and 2014.

The code of ethics is the cornerstone of the counseling profession. The code provides ethical guidelines in which counselors work within their profession. "Though a necessary aid, it is only to be used as a guide as it is not sufficient in exercising ethical responsibility" (Corey, 2010, p. 7). First and foremost the code of ethics does not have solutions to every issue; therefore, counselors are required to

use their own judgement and interpretations to provide best practices for their clients wherever an ethical and/or legal situation is encountered.

Other limitations include: conflicts with the law, institutional policies and practices, and other organizations' codes of ethics, conflicts with counselors' personal values, differing viewpoints of professionals, and the inherent ambiguity or lack of clarity within the code itself (Corey, 2010, p. 7). Despite counselor educators teaching the code, supervisors enforcing and reinforcing the code pre- and post-graduation, and licensing boards regulating the code at the state level, counselors are not being directly monitored. Instead they are being trusted to employ the code when needed and abide by the code where appropriate.

The ACA Code of Ethics is revised approximately every ten years (Kocet, 2009). Some recent revisions include the following: changes to sections pertaining to confidentiality, dual relationships, end-of-life care for terminally ill clients, cultural sensitivity, diagnoses, interventions, practice termination, technology, and deceased clients (Kaplan, 2009). One example of a recent revision is the update in regards to romantic and sexual relationships. Michael Kocet (2009) explained the significance of this change because of the power imbalance between clients and counselors. He explained how counselors must take caution not to take advantage of clients because of the sense of power clients oftentimes believe their counselor possesses. In the school setting, this is essential because of the sensitive nature of working with minors. This would be an example of where there is no conflict between the laws and ethical code since sexual relations with a minor is a violation of both the ethical code and legal laws. Kocet further explained that because of the power imbalance, the code has been changed from a two-year waiting period after termination of the client relationship before an intimate/sexual relationship can begin to five years after termination. This allows the counselor more time for closure and reflection and less chance that the vulnerability of the client will be exploited. This also allows for the power differential to settle and the client to successfully work through their therapy process and to make confident and autonomous decisions (Kocet, 2009).

The role of school counselors has obviously evolved. Guidance counselors in years past were viewed and employed in receptionist roles and tasked with responsibilities such as testing, scheduling, and other pseudo-administrative duties. Thankfully, and appropriately, school counselors are now valued for their true purpose to guide and counsel students through their academic, social and emotional needs. The ultimate goal of school counselors is to promote academic, career, social and emotional counseling to all students (Huey, 2011). Developing a rapport with their students is imperative for a successful relationship. Essential to success as a counselor is to stay up to date with local and federal laws, and collaborating with school administration, parents, and the community.

Included in this regular updating is the need to revisit the additional ethical guidelines pertinent to the school counseling profession. By staying informed and involved in the profession of school counseling as it evolves, counselors maintain the highest levels of professionalism and are aware of new trends and developments in the field. This all impacts the school counselor's decision-making ability, allowing the professional school counselor to make state of the art best practice decisions.

To assist in achieving these goals, the American School Counselor Association (ASCA) made over 40 new revisions in the Code of Ethics in 2010 (Huey, 2011). Topics that were changed or added were in the sections regarding technology, violence and safe schools, multicultural equity, confidentiality, danger to self and others, responsibilities to parents and guardians, referrals, groups work, and responsibilities to colleagues and professional associates. These have become topics of interest because of their significance and pervasiveness in recent years (Huey, 2011). Each of these topics has led to best practice programming changes in schools to address them on a school-wide basis as well as to provide a state of the art decision-making ability for all professional school counselors.

An important issue that almost all school counselors face is the dilemma of confidentiality. There have been numerous instances cited in the literature that could constitute breaching confidentiality with minors or coworkers in the school setting. Lazovsky recently did a study in 2008 in which he distributed and received questionnaires from 195 school counselors with explanations for what ethical dilemmas they deemed appropriate to breach confidentiality. He found that participants were most willing to breach confidentiality in dangerous situations, more likely for unlawful behaviors and least likely to breach confidentiality for personal or family situations. These decisions were based on ethical, legal, procedural, and professional reasons as well as the personal priorities of the counselor (Lazovsky, 2008). Counselors reported that they would breach confidentiality in less than half the cases provided in the study (Lazovsky, 2008).

The findings of Lazovsky's (2008) study demonstrate the commitment counselors feel towards their clients and the desire not to break confidentiality unless they feel it is absolutely necessary. This information can also be used to help trainees and interns develop ethical awareness and skills regarding the importance of confidentiality and its limitations (Lazovsky, 2008). In light of the research, it seems critical to remain involved in and abreast of the research in the profession as it expands and evolves not only in the area of confidentiality but in areas not even currently addressed by the ASCA Code of Ethics.

One topic that is exemplary of our rapidly changing society involves advances in technology, including both the advantages and challenges such changes bring to the professional school counselor. The ability to counsel clients and students online can be a valuable resource to students who may not have the option of face to face counseling. However, some school counselors are skeptical of online counseling due to lack of knowledge, the acceptance of counseling by students, honesty concerns from the student, and legal, ethical and privacy concerns (Glasheen, Campbell & Shochet, 2013). On the other hand, many counselors agree that if used properly, online counseling could be a useful counseling option for many (Glasheen, Campbell & Shochet, 2013).

Adversely, technology can pose challenges as well such as the trending issue pervasive within schools known as cyberbullying. With the easy access of technology, the use of the Internet, and mobile devices, children of all ages have access to email, websites, text messages, and social media that make it easier to bully others (Bhat, 2008). Additionally, in the last couple years there has been some concern regarding this issue at the federal, state and local levels. This is one particular area that school counselors can

anticipate being addressed in ethical code revisions.

Another current topic of concern from school counselors is the need for postsecondary preparation: college and career readiness. According to the U.S. Department of Education, more students are attending U.S. colleges and universities than ever before. Some counselors are concerned that there is not enough preparation for college and career entry for students as well as information regarding graduation plans with the local schools, administration, parents, and students (Glasheen, Campbell & Shochet, 2013). It is the author's contention that this is yet another topic that will likely be addressed during ethical code revisions.

The purpose of this study is to highlight what current school counseling professionals believe will be the areas to be addressed by the new revisions to the ASCA Code of Ethics. The survey is intended to address the concerns of school counseling professionals in the field.

All counselors are driven to guide and aid those in need of their services, in any setting. In addition to abiding by the ethical code, counselors need to respect clients' autonomy, do no harm, do good for the welfare of clients and the community, treat all clients justly and fairly, build a trusting, genuine relationship with clients, and act truthfully and honestly with clients (Corey, 2010). By following these principles and using an updated, relevant code of ethics we can better assist our clients, better serve our communities, and succeed in all our professional endeavors.

**2010 ASCA Ethical Standards Revision**

ASCA sent a brief to the leadership of School Counseling Associations. They informed leadership of the following

"The revised Ethical Standards will carry a 2016 date and will reflect an effort to include more voices and cast a nationwide net prior to the March 2016 public comment period. The leaders here today are being asked to start the process for revision by involving their state's SCA leadership to develop a process for suggesting revisions at the state level, and appointing a point person to relay state level suggestions for changes to the ASCA Ethical Standards Revision Committee.

**Annotated Timeline**

**June 27, 2015 to September 1, 2015. Develop a State Plan**

LDI participants contact state SCA's leadership and/or state ethics chair and develop a plan as to how your particular state will proceed to provide feedback for the standards revision. The approach and structure should meet your individual state's needs but the focus is on revising the ethical standards from the national perspective. There is not an ideal or prescriptive approach to the way of work by the states. The only requirement is that the leaders involve their state SCA leadership in determining the approach you want to use for state level revision suggestions. The approach to suggest revisions at the state level could be by committee, accomplished just by the appointment of one or two people, could involve state experts on particular subjects, or could include an invitation to all the state's school counselors. State participation at this level is optional but it is the hope that all 50 state SCAs will participate.

**September 15, 2015. Identify a Point Person and a Brief Description of your state SCA's plan.**

Identify the Ethical Standards Revision Point Person for the state through whom changes will be submitted to ASCA. Provide your point

person's name to ASCA at the link found on the first page of the ASCA website address www.schoolcounselor.org entitled *2016 Ethical Standards Revisions.* Provide a one-paragraph description of how you propose to tackle the revisions. This is a tentative plan as we recognize that sometimes when you get into the work your plan has to be adjusted.

**September 25, 2015. ASCA will Host a Webinar on the Revisions.**

Once your state's revision plan is in place, primary players identified by the state SCA are invited to participate in an ASCA webinar discussing the current standards, and the gaps, omissions, expansions, additions and deletions needed. The ASCA webinar entitled 2016 Ethical Standards Revisions will discuss in depth areas of focus, expansion, and/or creation. The webinar will be recorded for those who were identified as needing the webinar but were unable to attend.

**January 15, 2015. Final SCA Submissions Due**

A word document of the ethical standards can be found on the ASCA website at *2016 Ethical Standards Revisions. The point person from each S*CA submits their suggestions on this word document by using the tracking feature in word processing programs to show the changes.

**March 15, 2016 and April 15, 2016. Public Comment Period**

The *ASCA Ethical Standards Revision Committee* and ASCA Staff Liaisons will consider all state suggestions and post a draft for public comment available on the ASCA website between March 1, 2016 and March 30, 2016. All school counselors are invited to submit comments whether an ASCA or state association member.

**June, 2016. The 2016 ASCA Ethical Standards are Finalized**

The *ASCA Ethical Standards Revision Committee* ASCA Ethics Committee and ASCA Staff Liaisons will carefully consider all comments for possible inclusion and will submit the final draft at LDI during the 2016 ASCA Annual Conference.

**Louisiana School Counselors' Voices Matter Survey and Results**

The authors sent a survey to all members of the Louisiana School Counseling Association and asked for specific feedback in particular areas that ASCA requested pertaining to the creation of new standards or strengthening of old standards. Below is the survey disseminated to LSCA members.

***** Please note that the original survey is printed in black typeface, and the results are printed in black italics for your review.***

Thank you for agreeing to participate in this review and revision of the ASCA Code of Ethics. All school counselor's voices matter. In order to ensure that the code of ethics provides complete guidelines to members of the school counseling profession, your participation assures that ASCA will consider your recommendations for inclusion or expansion of the various areas of the code of ethics that are essential to your practice as a school counselor.

Below are links to the current code of ethics, as well as the various position statements formulated from the national ethics committee. Please review both documents before responding to the following questions.

**ASCA Code of Ethics Link**

https://wvde.state.wv.us/institutional/Counselors/ASCAEthicalStandards.pdf

**ASCA Position Statements Link**
https://www.schoolcounselor.org/school-counselors-members/about-asca-(1)/position-statements

*35 total participants*

**Sections A.2.a. and A.2.b.**

1. I feel like there is adequate information regarding confidentiality in the current code of ethics. (1-5 Likert-Type scale; 1=completely disagree, 2= disagree, 3=not sure, 4=somewhat agree, 5=agree).

*N=34*
*1 Completely Disagreed; 3 Disagreed; 5 Were Not Sure; 9 Somewhat Agreed; and 15 Agreed. 1 did not respond.*

2. What do you think should be added in sections A.2.a. and A.2.b. with respect to the following:
    a. Informed consent regarding confidentiality *(5 responses)*

*"how should confidentiality be handled when parents are separated or divorced, specifically with respect to the domiciliary parent; at what age is a person old enough to give consent"*
*"maybe something which covers electronic messages"*
*"parent section"*
*"Informed consent is so fuzzy in most schools. I would like more clarity on the laws as well as the ethics of having students/parents sign in regards to their knowledge of confidentiality when working with a school counselor."*
*"Each state should have guidelines according to state with specifics on disclosure of HIV/AIDS"*

    b. Cultural competence regarding confidentiality *(3 responses)*

*"address special concerns that may arise due to cultural differences"*
*"Disclosing a person's religious affiliations"*
*"parent section"*

    c. Limitations of confidentiality (2 responses)

*"what is the law with respect to teenagers having sex"*
*"parent section"*

    d. Special concerns with the developmental level of students with confidentiality *(3 responses)*

*"Guidelines to assist in determining adequate level of understanding"*
*"what if a child is 18 years old but not able to make decisions independently"*
*"parent section"*

    e. Making decisions on a student's behalf *(2 responses)*

*"who can make decisions on behalf of a student"*
*"parent section"*

    f. Responsibilities to parents concerning confidentiality *(3 responses)*

*"do both parents have to give consent for counseling and do both parents have to be informed about the process if one is unavailable"*
*"more specific guidelines"*
*"parent section"*

    g. Responsibilities to others involved in the child's education process *(2 responses)*

*"address the need to inform teachers and other staff members of information that may assist in certain classroom/school situations"*
*"parent section"*

3. Do you have any further suggestions for inclusion in sections A.2.a. and A.2.b. that is not currently covered? *(1 response)*

*"spell out the responsibilities of the parents in the child' education"*

**Section A.5.**

4. I feel like there is adequate information regarding referrals to outside counseling agencies in the current code of ethics. (1-5 Likert-Type scale; 1=completely

disagree, 2= disagree, 3=not sure, 4=somewhat agree, 5=agree).

*N=28*

*0 Completely Disagreed; 3 Disagreed; 9 Were Not Sure; 8 Somewhat Agreed; and 8 Agreed. 7 did not respond.*

5. What do you think should be added in sections A.5. with respect to the following:
   *a.* Cautions *(1 response)*

*"discontinue the counseling relationship with in a specific number of sessions"*

   b. Best practices *(1 response)*

*"data base of updated referrals resources"*

6. Do you have any further suggestions for inclusion in sections A.5. that is not currently covered? *(0 Responses)*

**Section A.3.b.**

7. I feel like there is adequate information regarding the use of data in the current code of ethics. (1-5 Likert-Type scale; 1=completely disagree, 2= disagree, 3=not sure, 4=somewhat agree, 5=agree).

*N=29*

*0 Completely Disagreed; 0 Disagreed; 10 Were Not Sure; 8 Somewhat Agreed; and 11 Agreed. 6 did not respond.*

8. Do you have any further suggestions for inclusion in sections A.3.b. that is not currently covered? *(1 response)*

*"with recommendation from the counselor"*

**Sections A.3. and Preamble**

9. I feel like there is adequate information regarding college and career readiness in the current code of ethics. (1-5 Likert-Type scale; 1=completely disagree, 2= disagree, 3=not sure, 4=somewhat agree, 5=agree).

*N=28*

*0 Completely Disagreed; 2 Disagreed; 8 Were Not Sure; 7 Somewhat Agreed; and 11 Agreed. 7 did not respond.*

10. Do you have any further suggestions for inclusion in sections A.3. and the preamble that is not currently covered? *(2 responses)*

*"THERE SHOULD BE MORE PREP FOR COLLEGE AND CAREER ENTRY"*

*"align with the individual graduation plan developed by parents, counselor, and student"*

**Section A.4.c.**

11. I feel like there is adequate information regarding social networking in the current code of ethics. (1-5 Likert-Type scale; 1=completely disagree, 2= disagree, 3=not sure, 4=somewhat agree, 5=agree).

*N=28*

*1 Completely Disagreed; 6 Disagreed; 5 Were Not Sure; 6 Somewhat Agreed; and 10 Agreed. 7 did not respond.*

12. What do you think should be added in sections A.4.c. with respect to the following:
    *a.* Cautions *(1 response)*

*"A completely new section should be created to address this. School counselors should be cautioned that any use of social media (professional or private) should follow all ethical guidelines."*

13. Do you have any further suggestions for inclusion in sections A.4.c. that is not currently covered? *(1 response)*

*"PREPARING FOR SOCITIAL ISSUES"*

**Section A.1.a.**

14. I feel like there is adequate information included in the preamble in the current code of ethics. (1-5 Likert-Type scale; 1=completely disagree, 2= disagree, 3=not sure, 4=somewhat agree, 5=agree).

*N=25*

*0 Completely Disagreed; 2 Disagreed; 7 Were Not Sure; 3 Somewhat Agreed; and 13 Agreed. 10 did not respond.*

15. What do you think should be added in the preamble with respect to the following:
    a. Responsibilities to students *(0 responses)*
    b. Responsibilities to parents *(0 responses)*

16. Do you have any further suggestions for inclusion in the preamble that is not currently covered? *(0 responses)*

**Section A.10.**

17. I feel like there is adequate information regarding technology in the current code of ethics. (1-5 Likert-Type scale; 1=completely disagree, 2= disagree, 3=not sure, 4=somewhat agree, 5=agree).

*N=25*
*0 Completely Disagreed; 4 Disagreed; 5 Were Not Sure; 7 Somewhat Agreed; and 9 Agreed. 10 did not respond.*

18. What do you think should be added in section A.10. with respect to the following:
    a. Managing boundaries *(1 Response)*

*"additional information concerning the relationship between FERPA and the ASCA code of ethics"*

    b. Documenting boundary crossings, considering role, time, and place *(0 Responses)*

19. Do you have any further suggestions for inclusion in section A.10. that is not currently covered? *(0 responses)*

**Non-existent categories**

20. Currently, there is no mention of the following topics in the current code. Please provide suggestions for inclusion in these areas for the future.
    a. Counseling in lieu of discipline *(5 responses)*

*"clarification on how this should work; cautions"*
*"outline specifying special populations and related concerns"*
*"counselors are counselors not disciplinary"*
*"Counseling should be in addition to discipline"*
*"YES!!! Definitely need more guidance on this topic."*

    b. Homeless youth *(3 responses)*

*"legal expectations concerning referrals and other methods of assistance"*
*"Mckinney Vento Act should be included"*
*"Informed Consent and disclosure"*

    c. Victims and perpetrators of dating violence, and sexual harassment *(1 response)*

*"I would mention something about not blaming the victims of different types of assaults."*

    d. Child abuse *(2 responses)*

*"what to do after it's been reported; next steps"*
*"yes, it should be explained"*

    e. Referrals and values *(2 responses)*

*"Must be made to a facility that has been in existence for 5 years or more"*
*"included on initial contact"*

21. Are there any topics not currently covered or proposed for inclusion in the next code of ethics that you feel should be considered? *(1 response)*

*"Case files and mandatory paperwork"*

**ASCA Code of Ethics Draft**

The results of the Louisiana survey were combined with the input from all of the other states and as a result, the following draft was created. https://www.schoolcounselor.org/asca/media/asca/Ethics/EthicalStandards2016Draft.pdf

Louisiana had valuable input into the draft, much of which was included. However, there were some relevant issues that were discussed among LSCA members that were added but not recommend from the survey results. Conversely, there was some wording that changed, but was not recommended by Louisiana School Counselors. For example, A.1.b. was added to include the following: "Counselors counsel but do not diagnose or provide clinical therapeutic services." The authors are encouraged by the responses from the LSCA members. Our hope is that all members will continue to provide feedback to the LSCA leadership, and ASCA, expressing the ideals of Louisiana school counselors.

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-Reshelle Marino and Peter Emerson with Catherine Redden

# Section I: Professionals' Articles

## The Multicultural Triadic Network Model in Supervision-of-Supervision

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This paper will provide a summary of the available literature on supervisor training; specifically supervisor training models, programs, and curricula. The authors will also discuss the Multicultural Triadic Network (MTN) model, drawing attention to the added layer of complexity that the supervision-of-supervision (SOS) element contributes. A case scenario will be provided to illustrate how the SOS network flows within the supervisory relationship. Finally, the authors will present specific implications of considering the cultural dynamics of each member of the SOS network in the MTN model.

*Keywords*: Multicultural Triadic Network model, supervision-of-supervision

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Due to the growing diversity of the U.S. population, the supervisory triad of client, supervisee, and supervisor will increasingly reflect differences in race, ethnicity, nationality, religion, gender, sexual orientation, socio-economic status, and disability, as well as their intersections (Ancis & Ladany, 2010). The importance of supervisor multicultural competence has been recognized by multiple researchers (Crockett & Hays, 2015; Soheilian, Inman, Klinger, Isenberg, & Kulp, 2014). However, literature dealing with an additional layer of complexity (supervision-of-supervision) in supervisory dynamics is not yet clearly addressed. This paper aims to expand on this area by providing an additional supervisor who supervises a supervisor-in-training with a framework to consider his or her influences on a supervisor-in-training, counselor, and client. Contributions to supervisor training models, programs, and curriculum from the existing literature will be discussed in the following section.

**Supervisor Training**

In spite of the fact that much attention has been given to supervision in the development of supervisees' multicultural competence, this is not the case for supervisors' development of multicultural competence (Bernard & Goodyear, 2014). Addressing this paradoxical circumstance is becoming imperative for the counseling field (Milne & James, 2002).The issue of training supervisors has only been emphasized in the past 25 years. The counseling field assumed that one's experience as a counselor provided sufficient knowledge and skills to make him or her a competent supervisor (Baker, Exum, & Tyler, 2002). Standards for supervisors, however, have since evolved and have been clearly defined by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) and the Association for Counselor Education and Supervision (ACES, 1990).

ACA's latest (2014) Code of Ethics included a section on "Teaching, Training, and Supervision" (Section F). Supervision has been recognized as a discipline which is different from counseling (Bernard & Goodyear, 2014). The recognition that supervision has its own body of knowledge and skills has marked the training of supervisors as important. CACREP-accredited doctoral programs are required to offer content in supervision (CACREP, 2016). Moreover, CACREP (2016) also identified the training of on-site supervisors as a requirement for counselor education programs.

In response to the call for competent supervisor training and its importance, multiple supervisor training guides, programs, and models have assumed a place in the literature (Bernard & Goodyear, 2014; Bradley & Whiting, 2001; Falendar & Shafranske, 2004; Garrett, Borders, Crutchfield, Torres-Rivera, Brotherton, & Curtis, 2001; Granello, Kindsvatter, Granello, Underfer-Babalis, & Hartwig-Moorhead, 2008; Inman & Ladany, 2014). Bradley and Whiting (2001) suggested that there are four main goals of supervision training (1) to offer a theory or knowledge linked with supervisory functioning; (2) to develop supervisory skills; (3) to incorporate a theory and skills into an effective supervisory style, and (4) to mold the professional identity of the supervisor. However, this version of supervision training is 15 years old; it sounds culturally invisible because it fails to address multicultural competence.

Borders, Bernard, Dye, Fong, Henderson, and Nance (1991) presented a standardized curriculum for training supervisors which sheds light on three curriculum threads: self-awareness, theoretical and conceptual knowledge, and skills and techniques. Borders et al., (1991) also introduced seven core curriculum areas: models of supervision; counselor development; supervision methods and techniques; supervisory relationship; ethical, legal, and professional regulatory issues; evaluation; and executive (administrative) skills. This version of supervision training is 25 years old, and also does not attend to multicultural issues. Additionally, Borders and Brown (2005) named four curricular content areas for training supervisors: counselor development, supervision methods and techniques, the supervisory relationship, and models of supervision. This version of supervision training is 11 years old, and likewise does not address multicultural issues.

In addition to content in training, McMahon and Simons (2004) found that short-term training could result in increased supervision scores on post-tests and that gains were maintained over six months; however, Kavanagh,

Spence, Sturk, Strong, Wilson, Worrall, & Skerrett, (2008) opined that limited benefit was attained from a brief supervision workshop. Crook-Lyon, Heppler, Leavitt and Fisher (2008) proposed that supervisory development scores had a connection with the amount of supervisory training and mentored supervision hours for novice supervisors. These studies, nevertheless, did not indicate or focus on multicultural supervisor training.

Various scholars presented models of supervision that focus on cultural issues within supervision (Ancis & Ladany, 2010; Garrett et al., 2001; Gonzalez, 1997; Tang & Braun, 2015). Those models, however, were not validated or empirically tested (Garrett et al., 2001; Gonzalez, 1997; Tang & Braun, 2015). Gonzalez (1997) suggested that supervisors integrate linguistic diversity into their models of multicultural supervision. According to Garrett et al. (2001), the VISION model of multicultural supervision emphasized the supervisor's awareness of his or her own culture and how this affects the supervisee and subsequently, the supervisory process. Ancis and Ladany (2010) presented the HMNID model which looks at the process of learning and supplies a method for understanding the multicultural competence of both supervisors and the counselors with whom they work. Tang and Braun (2015) discussed the complex interrelationship shared by supervisors, counselors, and clients; which forms the Multicultural Triadic Network (MTN) model (See Figure 1.)

From the MTN perspective, the multicultural competence of the supervisor influences the multicultural competence of the supervisee, which then influences client outcomes and the counselor-client relationship. Therefore, the supervisor indirectly influences the client's success via a trickle-down effect. These influences can be internal (e.g., implicitly through the relationship or through mirroring), or they can be external (i.e., through intentional interventions). The extant models of multicultural supervision do not appear to draw attention to the additional layer of complexity when the supervision of supervision (SOS) element is recognized; thus, the impact of the supervisor-of-supervisor is not yet clearly addressed in multicultural supervision models and seems worthy of further discussion.

## The Multicultural Triadic Network (MTN) Model in Supervision-of-Supervision (SOS)

In this paper, the authors consider the additional layer of complexity when the SOS element is applied to the MTN model. In SOS, an additional supervisor supervises a supervisor-in-training. For the purposes of this paper, this supervisor-of-the-supervisor will be referred to as the *grand supervisor*, and the supervisor-in-training will be referred to as the *supervisor*. When MTN takes into account an SOS relationship, the model is similar, but an additional set of interrelationships is added to the network (See Figure 2). Specifically, the grand supervisor's multicultural competence influences the supervisor's multicultural competence, which then influences the counselor's competence and the client's outcomes. As these ideas are discussed in this paper, readers should note that the MTN has not yet been tested through research and that the authors are merely offering a new way for supervisors to consider their influence.

## Case scenario

To illustrate the concepts presented in this paper, consider the following multi-level case scenario.

**Grand Supervisor: Dr. Jobst**

Dr. Jobst, an experienced LPC supervisor and tenured professor, begins a SOS relationship with her doctoral student, Chen. This will be Chen's second semester as part of his doctoral internship supervising counselors-in-training. In preparing for her SOS session with Chen, she considers the following:

*Chen is a skilled counselor; he embraces multicultural awareness in his own practice of counseling, but I'm not sure he has yet developed his skill in facilitating it in his supervisees. This will be a critical aspect in helping his supervisee, Jennifer. Jennifer has developed her skills and has embraced multiculturalism but has not yet demonstrated it in practice. Chen has already had experience with Jennifer as he was a TA for her Skills class, and he is concerned that she may not be aware of her assumptions. I should collaborate with Chen to find a way to help Jennifer.*

Dr. Jobst: I understand you are concerned about your new supervisee and her multicultural awareness. What part do you find challenging?

Chen: I'm not sure how to broach this with her. Jennifer is White, and I'm afraid if I say it the wrong way, she will think I'm being overly-critical.

Dr. Jobst: Can you elaborate on this fear?

Chen: I know that early in some students' development, especially of a majority group, they may see the idea of developing more multicultural awareness as a shortcoming. I'm afraid if this is true of Jennifer, she will think I'm attacking her.

Dr. Jobst: Now, from what I know of your work, you have had quite a bit of experience broaching cultural difference as a counselor, and I imagine you had some success with that. Could you tell me what made you successful in those situations?

**Supervisor: Chen**

Chen considers his Supervisee. His thoughts are as follows:

*Jennifer is early in her development of multicultural competence. She has assumptions about Cyrus' cultural status, but she is not aware that they are assumptions. Specifically, she assumes that since her client is African-American that he has strong Christian beliefs. While this could be true, this assumption is contributing to her anxiety (since she is Atheist), and she does not seem to consider a different possibility. Additionally, she believes that if she just does "good counseling" that multicultural competence will happen naturally. She is nervous about the unknown. In my childhood, I interacted with many people who were culturally different from me. I may be able to draw from my experience in broaching cultural difference with her.*

**Supervisor's external interventions**

Chen: As you probably noticed, there is a difference in our cultural backgrounds. My ethnicity is Chinese, and I'm not sure what your background is. Maybe you could share about your cultural background and your experiences so that I can have an idea of the perspective that you'll be using when working with clients. Would you feel comfortable sharing that with me?

Jennifer: Sure! I'm White as you can see, and I'm from the Midwest, and I guess that's my background. Let's see. What else? My parents got a divorce when I was too young to remember. Not long after that, they each got married to someone else. I really like my step-parents and definitely consider them part of my family. When I was a kid, my siblings and I really liked having that split, as strange as that might sound.

Christmas always came twice each year!

Chen: Thanks for sharing. So, it sounds like your status as a person from a blended family has shaped your worldview quite a bit and perhaps carries more meaning for you than your ethnicity does. Does that sound accurate?

Jennifer: Yeah, I don't think very much about my ethnicity. I know that my family is German and Swedish, which makes me White. After having the course on multiculturalism, I know that White isn't "neutral" or the "absence of race," but my Whiteness is not something I think about.

Chen: I wonder why not?

Jennifer: Well, I suppose because I haven't been expected to think about it very much up until this program. I also don't think about spirituality that much. I'm an atheist; so spirituality doesn't have much influence over my worldview.

Chen: These are great details for me to know about your background, and we'll be addressing the possible effects these dynamics might have with your sessions with clients throughout the semester. Let's shift gears slightly and talk about your upcoming client. You said he is African-American, and there may be other cultural differences as well. What feelings are you having about your upcoming first session with him?

Jennifer: Well, I'm having a lot of anxiety. I'm afraid I'll say the wrong thing and he'll think I'm racist, which I know probably won't happen. I can't help but think about it though. A more realistic fear that I have is that he won't think I'll have anything to offer him. He might think to himself, "What could this young, White girl possibly have to tell me?" My other fear is that he might not approve of the fact that I'm an atheist.

Chen: Well, we can address each of these if you wish. Which issue seems most urgent?

Jennifer: I suppose the spirituality aspect.

Chen: Okay, let's start there. I'm having a number of thoughts about spirituality as it pertains to this situation. One is that, yes, many people with African-American backgrounds identify as Christian, but that is not necessarily the case with Cyrus. The one that jumps out at me most is that spirituality is an invisible cultural status. Have you heard that term before?

Jennifer: Sure, it means people can't necessarily tell that I'm of a certain status just by looking at me.

Chen: Right! So what does that mean for the counseling relationship?
Jennifer: Well, I guess that means I don't necessarily have to reveal it to him… But wouldn't I be disingenuous if I did that? Wouldn't I be lacking in authenticity if I kept that part of myself from him?

Chen: Well, in a sense. Think back to your introductory counseling skills course. What do you remember about self-disclosure?

Jennifer: I was taught that self-disclosure is best used minimally and only if it is used in the best interest of the client.

Chen: That sounds pretty accurate. So with that in mind, in what

circumstances would it be in the client's best interest to reveal that part of yourself, and in what circumstances would it be less helpful?

Jennifer: Well, I suppose it would be in the client's best interest if I knew it wouldn't hurt the relationship, which I might need to get to know him a bit more first in order figure that out. It would be less helpful to reveal that status if I wanted to use it as a way to satisfy my own needs, which I will avoid at all cost.

Chen: Okay, those are good thoughts. So what do you make of that information as it pertains to your dilemma on whether or not to reveal your invisible cultural status to the client?

Jennifer: Well, when I think about it that way, I think I might wait to reveal that I'm an atheist.

Chen: And how did you come to that decision?

Jennifer: If my goal is to address cultural issues to strengthen the working alliance, it might be more helpful to focus on his perspective than on mine. I should be aware of my own so that I can increase my understanding of the dynamics, but I think that if I were to reveal to him that I'm an atheist, I would be seeking acceptance from him rather than trying to address his issues.

Chen: More good thoughts! Let's continue to explore this. If you choose to wait before revealing that you are atheist (and perhaps even never reveal it), what do you plan to do instead?

Jennifer: I'm not sure… [silence]

Chen: Let's draw from your prior experience. How have you handled this when it has come up in your personal life?

Jennifer: Well, I tend to keep it hidden in my personal life also. So that will be a helpful way to think about it. [Jennifer is silent in thought for a moment.] I think the fact that I'm so agreeable (which might be my Midwestern influence) makes it easy for me to accept others' perspectives as valid. As a person growing up in the Midwest, most everyone else that I knew was Christian, which obviously is not a belief system that I would like to live by. However, I see why others do.

Chen: That sounds like the beginning of empathy to me! It sounds like you have been able to separate your own worldview from others' while conveying respect. Does that sound accurate?

Jennifer: Yes!

Chen: And how did you convey that respect?

Jennifer: Well, I would just try to be supportive and remember that their values might not match mine, those values still mean a lot to them. For example, one of my best friends from home is Christian, and even though I don't normally go to church, I attended her wedding, which took place in a church. I also attended her grandmother's funeral. I knew she wanted my support; so I made sure I was there for her.

Chen: Great! So as you get to know your upcoming client, you'll have to figure out what it means to "go to church" for him, so to speak.

Jennifer: [laughs] Yeah, I think that will be helpful.

Chen uses a counseling intervention.
Chen: Let's talk about your anxiety about your client's perception of you as a White female. Say more about that.

Jennifer: I guess since I'm a young, White female from the rural Midwest, I don't think he'll see me as a relatable. Since I'm young, he might think I haven't experienced enough of the world to understand him, especially since he's African-American, which is a big part of his experience. My biggest fear is that he might be right! Maybe my limited experience will make it too difficult to build a relationship with him.

Chen: It sounds like you're focused on the differences between you and your client. Maybe it would be helpful to look at the similarities between you and your client. Since you haven't met with your client yet, you may not know what those are yet, but let's imagine what they might be. What is your client's presenting problem?

Jennifer: Due to mental health issues (ADD and depression), he has difficulty keeping a job.

Chen: And he's employed now?

Jennifer: Yes, he works as a cook on a food truck.

Chen: Okay, imagine how he might feel.

Jennifer: Well, I bet he's afraid that he won't have any income if he loses his job. Plus, I'm sure he feels sadness since he is diagnosed with depression.
Chen: Can you think of a time in your life when you had similar feelings?

Jennifer: Definitely, when the economy wasn't doing so well a few years ago, I had a really hard time finding a job. It was scary to think about how I would pay my bills and survive.

Chen: It sounds like you've experienced something pretty close to at least one aspect of the client's experience.

Jennifer: I suppose I am capable of relating to him. So now I suppose the challenge will be in conveying that.
Chen: And you'll do that by using reflection of feeling and all of the other elements of basic empathy that you learned in your skill course. The added layer here will be the multicultural lens. As we discussed before, you'll want to keep culture in mind as you listen to every word the client says and as you process every one of your own thoughts. It may not apply to everything, but it could apply to anything. That will be a helpful way to think as you listen to and think about your client.

**Counselor: Jennifer**
**Counselor's internal cultural competence (initial)**

*I am nervous about meeting Cyrus for our first session. He will probably see me and think, "What could this young White girl possibly tell me about life? She never had to struggle the way I have!" And maybe he is right! Maybe I can't relate to him. After all, we are so different from each other. It is going to be difficult to see the world through his frame of reference.*

**Supervisee's internal cultural competence (post-intervention)**

*Maybe I am capable of relating to Cyrus; I may not have experienced the same things he has, but I have felt similar feelings. If Cyrus doesn't initially see that, that's okay; I'll just have to work to convey it to him. Also, I can draw from earlier experiences with cultural difference. This may be a new and*

*different situation, but I can apply some of the thing that I already know I'm good at. Specifically, I am able to be supportive of worldviews that I myself don't live by. Who knows? He may have a worldview that I don't expect! Whatever his worldview, I will try to figure out how to "go to church" for him.*

Before Jennifer spoke with Chen, she had no initial plan. She planned to simply counsel Cyrus the same way she had been counseling others and hope for the best. Jennifer would have been able to make some astute reflections and gather some information; however, she would have left that session feeling as though something was not quite right, and she would not know why. The answer would have been that she would not have applied a multicultural lens, which caused invisible barriers to forging a strong working alliance with Cyrus. After speaking with Chen, Jennifer felt more comfortable broaching cultural differences with her client and confident in using existing strengths to strengthen the working alliance.

The following is her first session with Cyrus.

**Client: Cyrus**

Jennifer: Cyrus, welcome!

Cyrus: Hello.

Jennifer: So I understand you've got something you'd like to work on.

Cyrus: Yes, I've had depression for a few years. The medication I take makes it less severe, but I still feel a little bit fatigued at work. I also have a hard time concentrating because of my ADHD. I haven't been able to hold a job very long because my fatigue and lack of focus makes it hard for me to be a good worker. I have a job now, but I'm worried I'll lose it.

Jennifer: To be honest with you, I have never been in that situation. So it wouldn't feel right for me to tell you that I understand, but when I imagine that situation, it sounds scary and discouraging.

Cyrus: Yes, it is.

Jennifer: Maybe you could tell me a little more about your job. Would that be okay?

Cyrus: Sure, I'm a short-order cook at the diner down the street. Focus and energy are important because I need to be able to keep track of what I'm cooking and make sure I'm getting it done in a timely fashion. I love cooking, but I'm not sure I'll be able to work fast enough to make my boss happy.

Jennifer: What's your boss like?

Cyrus: He's nice enough, but his father bought the diner for him.

Jennifer: Mhmm, and can you help me understand what about that is important to you?

Cyrus: Well, he probably sees me as replaceable. It's easy to find people to do this kind of work, and he doesn't appreciate how important the paycheck is to me.

Jennifer: It sounds like you've had bosses that have not valued you before.

Cyrus: Yeah, and they wouldn't cut me any slack at all.

Jennifer: So you feel like you can't make any mistakes.

Cyrus: Right… I don't know what I'm going to do…

Jennifer: Before we go further, I want to take a moment to acknowledge something. I know it's possible that you see me as young and inexperienced, and that I may not be able to relate to you. That would be an understandable perception. Our cultural and racial backgrounds are different, and our experience of the world has been different. I wonder what challenges we'll have because of this difference.

Cyrus: That's a good way to put it I think. When we started, I was hesitant because I honestly didn't think you would understand, and it turns out you don't [smiles], but at least you're being honest about it. I appreciate that.

*Jennifer fostered a strong working relationship with Cyrus through authenticity and a willingness to begin courageous dialogue about race, culture, and their dynamic effects on the therapeutic process. Because of this, the possibility of a positive outcome exists. Without Chen's intervention and internal cultural competence, this possibility may not have arisen because Jennifer may have continued to avoid broaching cultural difference. Without Dr. Jobst's interventions, Chen may not have been able to form a supervision intervention quickly enough for Jennifer to process it before her session. Thus, the interconnections of the SOS network and the MTN model have been exemplified in the above scenario.*

## Implications

Viewing the supervision and SOS process as a network of interrelated influences as is proposed by the MTN model (Tang & Braun, 2015) may benefit grand supervisors, supervisors, counselors, and clients. In addition to being reminded of the responsibility that counseling professionals have to their colleagues and the consequences and seriousness of their work, there are also some specific implications for multicultural competence. Particularly, the MTN model draws attention to the cultural dynamics of each member of the SOS network.

Grand supervisors and supervisors may find it useful in the interventions they select when working with counselors-in-training, and, while doing so, they may be more mindful of both their internal and external competence. When the idea of an SOS network is taken into account, it allows grand supervisors to see the cultural dynamics that may be at play. When cultural differences exist at every level of the network (which is likely when all aspects of culture are taken into account), grand supervisors may consider how each other SOS network member's culture is affecting the other.

The MTN model is currently untested, and is not intended as an absolute truth. Rather it is intended as a way of seeing the supervisory process. Therefore, testing the model itself may not be as beneficial to researchers as testing the influences of certain variables and following those influences through each level of the model. For instance, if a researcher views supervision from the MTN lens, then she or he may wish to test the efficacy or a certain type of intervention. Through Structural Equation Modeling (SEM), path analysis, or factor analysis research methods, the researcher could test that interventions' efficacy at the various levels (i.e., grand supervisor, supervisor, etc.) as desired. Therefore, the MTN can act as a framework for how the supervisory process is seen by practitioners and researchers.

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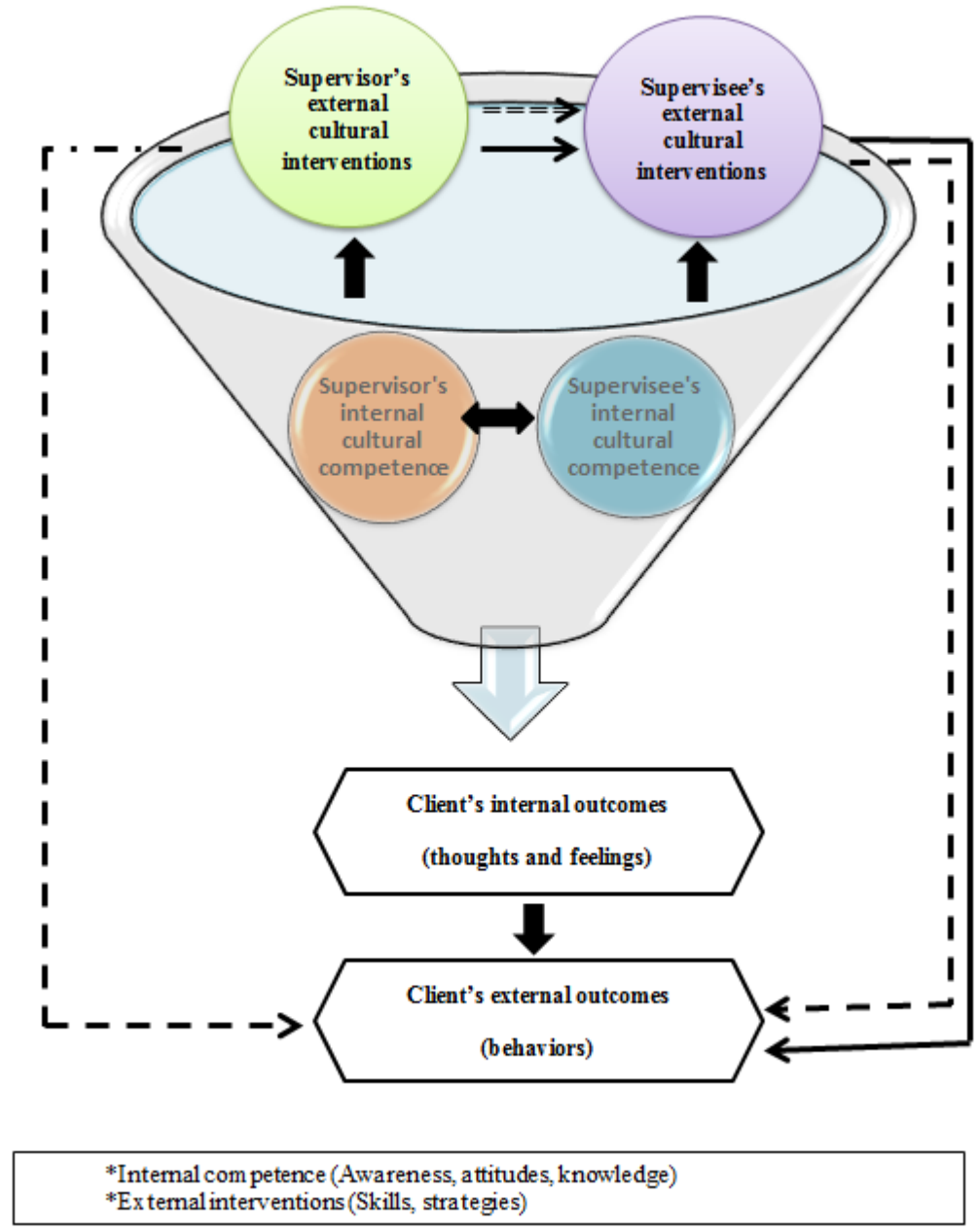
Supervisor's external cultural interventions
Supervisee's external cultural interventions
Supervisor's internal cultural competence
Supervisee's internal cultural competence
Client's internal outcomes
(thoughts and feelings)
Client's external outcomes
(behaviors)
*Internal competence (Awareness, attitudes, knowledge)
*External interventions (Skills, strategies)

Figure 1

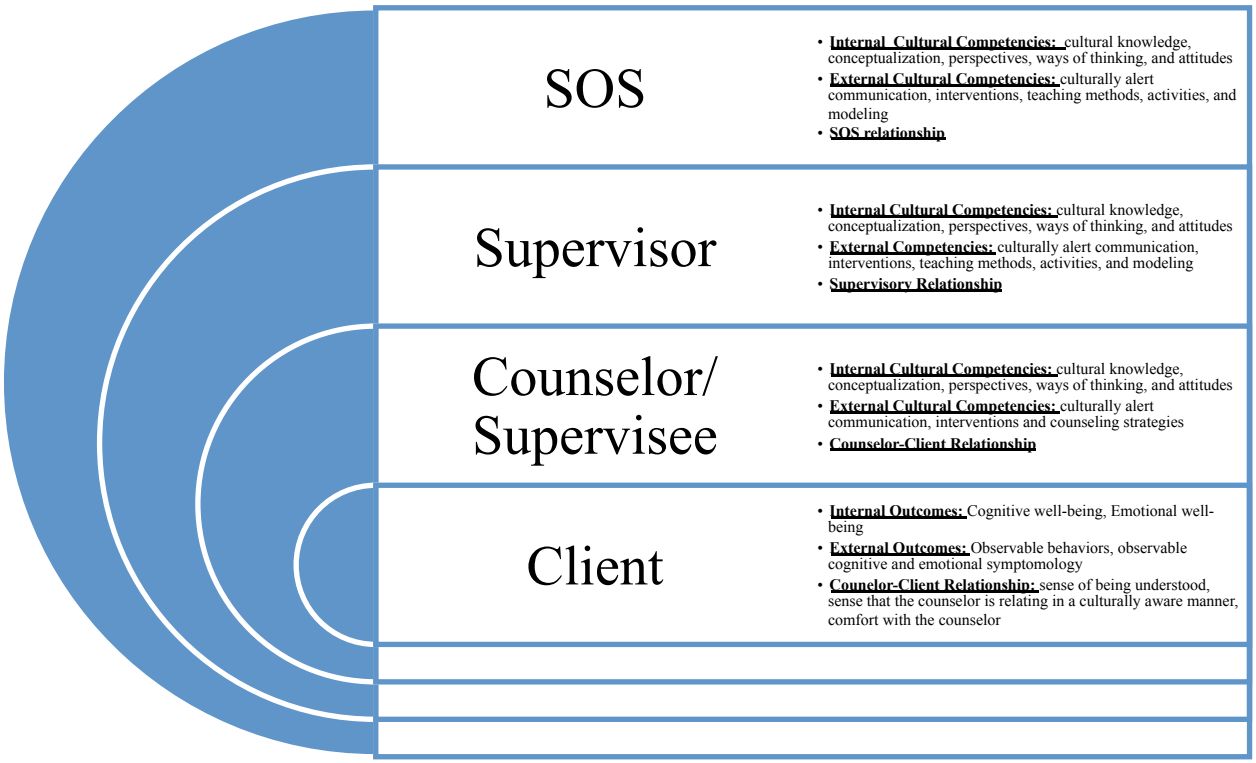
SOS
• Internal Cultural Competencies: cultural knowledge, conceptualization, perspectives, ways of thinking, and attitudes
• External Cultural Competencies: culturally alert communication, interventions, teaching methods, activities, and modeling
• SOS relationship
Supervisor
• Internal Cultural Competencies: cultural knowledge, conceptualization, perspectives, ways of thinking, and attitudes
• External Competencies: culturally alert communication, interventions, teaching methods, activities, and modeling
• Supervisory Relationship
Counselor/ Supervisee
• Internal Cultural Competencies: cultural knowledge, conceptualization, perspectives, ways of thinking, and attitudes
• External Cultural Competencies: culturally alert communication, interventions and counseling strategies
• Counselor-Client Relationship
Client
• Internal Outcomes: Cognitive well-being, Emotional well-being
• External Outcomes: Observable behaviors, observable cognitive and emotional symptomology
• Counelor-Client Relationship: sense of being understood, sense that the counselor is relating in a culturally aware manner, comfort with the counselor

Figure 2

# It Ain't your Mama's Yoga! Transformations Utilizing the DDP Yoga System; a Qualitative Case Study

**Pete Cooper M.S., LPC-S, Ph.D. Candidate**

In this study, a single qualitative case study to examine the transformations that occurred in a participant who has engaged in the Diamond Dallas Page (DDP) yoga system for 6 years was utilized. DDP yoga is the workout created by 3 time WCW champion Diamond Dallas Page. Two in depth open-ended interviews were conducted with the participant. The first interview was conducted to gather raw data, and the second interview was conducted to validate the data. Eight first order themes were established in the first interview which consisted of a) injuries (physical and psychological), b) weight, c) pain management, d) previous yoga experience and experience with DDP yoga (benefits of practice), e) vocational implications, f) experience with teaching yoga, g) pivotal points that led to feelings of hopelessness and h) increases in mobility. A general interpretive case method was used to discover the tacit dimensions and group meaning units.

*Keywords:* yoga, qualitative case study, transformation

Yoga has become increasingly ubiquitous in the United States. Yoga classes are offered at fitness centers around the country, yoga-related clothing has established a significant market niche, and the media even reports on celebrities' yoga routines (Siven 2012). Yet this modern-day phenomenon, which has been described by scholars as both "energy medicine" and "mind-body medicine," has a long history of practice in India, possibly dating back 5,000 years (Chaoul and Cohen 2010; NCCAM 2010). Nevertheless, yoga as it is practiced today actually only dates back to the early 20th century, and many practitioners are unaware of this history (Singleton 2010). The pursuit of health (in addition to spiritual goals) has been identified as the main reason for dedicated yoga practice (Hoyez, 2007). A wealth of social science scholarship shows that consistent yoga practice is used by practitioners as a form of medical system and a self-care strategy, in addition to being perceived by practitioners as a contemporary transnational spiritual community (Strauss, 2002). Public health and medical perspectives on yoga show a variety of health benefits related to major chronic conditions, including cardiovascular disease, problems with blood glucose, blood pressure, weight, or sexual function, as well as maternal comfort during labor (Bijlani et al. 2005; Chaoul and Cohen 2010; Dhikav et al. 2010; Harinath 2004; Kaur et al. 200 1 ; Narahari et al. 2008; Robertshawe 2009; Ross and Thomas 2010; Yang 2007). Positive psychological effects have also been identified (Birdee et al. 2008; Kissen and Kissen-Kohn 2009). For instance, yoga has been termed as a way of strengthening self-soothing, which can be important to recovery from illnesses (Calajoe 1986; Kissen and Kissen-Kohn 2009). There have also been claims that yoga practitioners have the ability to voluntarily self-regulate blood pressure and modulate body temperature (Levin 2001).

The International Association of Yoga Therapists (IAYT) defines yoga as: the process of empowering individuals to progress toward improved health and well-being through the application of the philosophy and practice of yoga" (IAYT, 2007). The use of yoga to treat mental illness and disease dates back nearly 8,000 years (Barton, 2011). Barton (2011) also illustrates that although yoga is not traditionally considered a form of psychotherapy, it has been shown to have a significant positive psychological impact on many of its practitioners. There exists a growing body of research that explores the benefits of using yoga, meditation, and/or other Eastern body-based interventions in clinical facilities serving psychiatric populations (Davis, Strasburger, & Brown, 2007; Elkins, Rajab, & Marcus, 2005; Kozasa et al., 2008; Weiser, Kutz, I., Kutz, S., & Weiser, 1995).

Some studies have shown that there are significant improvements in mood and anxiety symptoms of psychiatric patients after participating in yoga or meditation (Davis et al., 2007; Kozasa et al., 2008; Lavey et al. 2005), and modest improvements were revealed in a 4-month study of yoga therapy as an add-on treatment in patients experiencing schizophrenia (Duraiswamy et al., 2007). According to Dilliard (2002), in an extensive survey of people with back pain conducted in the 1980's, 96% of those who had tried yoga for pain reported moderate to dramatic long term relief and the remaining 4% reported being helped on a temporary basis. Though the historical (and more recently Westernized) significance of yoga has been quantified and the various schools of yoga have also been studied, the Diamond Dallas Page (DDP) yoga system has yet to see the light of day in the clinical and scientific literature. Therefore, it is the researcher's contention that bringing this new system of yoga to light and illustrating its benefits in the following case study will further the scientific literature in this area.

## Methodology

Qualitative Case Study

According to Creswell (2007), case study research is a qualitative approach in which the investigator explores a bounded system (case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information (for example, observations, interviews, audiovisual material, documents, and reports), and reports a case description and case-based themes (p.73). Also, according to Creswell (2007), three variations exist in terms of intent: the single instrumental case study, the collective or multiple case study, and the intrinsic case study. The researcher has elected to utilize the intrinsic case study as the strategy for this study for reasons that will become evident in the following transcripts. Qualitative case study is merited for its particular usefulness in counseling research because the method is more relevant and more realistic to the 'lived' experiences of clients. Additionally, qualitative case study is more flexible and fluid in discerning complex psychological constructs, and can generate more clinically and pragmatically relevant findings (Dattilio, 2006). This case study specifically focuses on one subject, Stanley, and his experience with the DDP yoga system.

The rationale behind employing the intrinsic case study was based on the gap in the scientific literature on DDP yoga specifically; as well as the nature of Stanley's case which will be illustrated in depth in subsequent sections. In short, the fact that an

individual who walked on canes for fifteen years, was relegated to palliative care by physicians, and had extreme limited mobility due to weight and other issues was able to overcome these obstacles is not a usual case without the aid of a purely medical and/or synthetic means of transformation (gastric bypass surgery and other forms of medication and surgery etc.). His transformation was completely natural.

**Data Collection and Analysis**

The interview questions were constructed and conducted by the author based on, and influenced by, his extensive experience in the mental health field working for over 15 years with clients with special needs issues and/or those with morbid obesity. Interview questions and the content of the interview questions were not made available to Stanley before the interview took place. Triangulation of data took place by conducting two semi-structured open ended interviews one month apart from each other. The first was the data collection interview, which took one hour and five minutes to complete. The interview was recorded and transcriptions were created from the audiotape verbatim. The structured questions were woven into the interview following the semi-structured format and answered by Stanley.

The following questions were addressed in the first interview and raw data was collected: How old are you? What injuries did you incur before starting the DDP yoga system? How did you sustain the injuries? What did the pain feel like? How did the injuries limit you physically? How did the injuries limit you psychologically/emotionally? How did you get involved with starting the DDP yoga program? How long have you been practicing the DDP yoga system? How much did you weigh before starting the DDP yoga program? How much do you currently weigh? What have been the physical differences for you from your first day of starting the DDP yoga system and today? What have been the psychological/emotional changes for you from your first day of starting the DDP yoga system and today?

Upon completion of the interview and transcriptions, the first order themes were established based on the responses given by the participant. An open coding methodology was used to stratify the data into themes at this point. Eight first order themes were evident based on the transcriptions of the data which consisted of the following: a) injuries (physical and psychological), b) weight, c) pain management, d) previous yoga experience and experience with DDP yoga (benefits of practice), e) vocational implications, f) experience with teaching yoga, g) pivotal points that led to feelings of hopelessness and h) increases in mobility. The themes of experience with teaching yoga, pivotal points that led to feelings of hopelessness and increases in mobility became evident in the follow up interview the following month based on elaborations of the finding of the raw data. The follow up interview consisted of questions validating the raw data from the first interview and these latter themes became evident at this time. The validation interview was also recorded and transcripts were constructed verbatim from the audiotape.

The author sent the transcripts to Stanley to further solidify his statements and aside from some grammatical errors in the transcriptions, Stanley indicated that the raw data and themes were congruent with what he was stating verbally in the interviews. The triangulation of data was concluded for trustworthiness through an external auditor and reviewed prior to sending to

Stanley. The second order themes were concluded through group meaning units, tacit dimensions and general interpretive case method. Axial coding was utilized at this point to specify and further streamline the thematic elements presented.

## Results

The following are Stanley's interview responses.

**Theme I –Weight**

**Stanley:** *My heaviest was around 340 lbs. Now the thing is that I don't have a bariatric scale. So, what I had to do was….I stood on two scales….and I combined the weight. Then I stood on the two scales with a 5 lb. weight…combined the numbers….stood on the scales with a ten lb. weight…combined the numbers…and I gathered up a set of data points…and then I figured…ok the combined numbers = x + 5…the combined numbers = x + 10….the combined numbers = x + 15 and I worked out an algorithm to determine what the deviation was between the 5, 10, 15 lbs. and to get really technical I know I should have used a logarithmic scale but the problem is to extend those data points in a logarithmic scale would have given me too much variation in the influx to make it all work. So I ended up using the linear scale because that was easiest to compute…..so I ended up running it as a linear regression and determined what the deviation of the two scale weight was. So, I was able to figure out that my weight was approximately 340 lbs.*

***Stanley:*** *Right now, I'm about 175 so I really need to drop about 5 or 10 lbs., but my weight fluctuates a little bit and that's something…..how do I put this…..that's something that I have to constantly be on the watch for because bad habits are still there. It's not like….how do I put it…a person with a drinking problem can physiologically stop drinking alcohol….a person with a drug problem can stop taking drugs….I cannot stop physiologically eating.*

**Theme II – Injuries (Physical and Psychological)**

*I have had so many injuries. I was in a couple of different vehicle accidents. I have been in a helicopter that went down. Broken arms, broken legs, caved in chest, broken back…….various projectile injuries….I've been hurt a lot. I could not stand on my own…the fact that I had a hard time even sitting up. I was so heavy that chairs broke under me. I was at that time was basically waiting to die.*

***Stanley:*** *I was not suicidal. I had the view of myself as being basically terminally ill. A guy my size…that weight…I couldn't breathe. I passed out once in front of a classroom full of kids. I had been told that I was not going to get better.*

*I believed that I was going to die. I believed quite fully that my weight was going to kill me. I did not think that it was going to get better. I pretty much had given up. I was expecting to die and I was not looking….I was not suicidal…please do not misinterpret. I was not planning to kill myself or anything, but I was waiting for it to be over. I believed that I was not going to get better and was fully expecting that I would have the massive heart attack or the big stroke or just whatever…. My big thing that I was hoping for, was that I would die in my sleep. I was so heavy…and between that and the nerve problems that I had, they would not let me drive. In fact, to this day, I cannot drive a regular car. Nerve damage. My reflexes are not adequate to let me drive a regular car. Braces were holding me up and my back would spasm badly because it just could not maintain the effort that it was putting out and what happened was basically, it was just*

*knotting up. It was knotting up so badly that it was grinding my spine into the nerves. Now, the end of it is just that my back muscles were so weak that they could not do what I was expecting them to do and that is what was causing me all the pain. My back muscles would finally just give out. Oxycontin turned me into a zombie. I mean I had given up on having any hope of a physical life. I had given up on my hobbies. I had given up on everything.*

*My decision making skills were not compromised. I was not acting psychotically or irrationally….I was perceiving logically from inaccurate information. If someone told you that x = 5 and they said what is x + 1, you would say 6. If on the other hand x is really 4, but I told you it was 5, you would still say 6; your answer would be wrong. You would apply logical skills to incorrect information; that's where I was at. I was applying…..I was thinking, "ok this is the best that I can do" and the truth is…it wasn't, but because I had been told that these things don't get better, I believed it.*

**Theme III – Pain Management**

*Well, to be honest, when I first started, I was not looking for weight loss. I was not looking for any kind of physical recovery when I first started. Stanley: pain management. I was looking for something to help me manage the pain. That was why I started looking for yoga. Because a long time before I had had some small experience with yoga and at the time I was rucking every day and I knew that that would help me manage the stress in my back. So having had that experience before with yoga I knew that it could do me some good and I was desperate to try basically anything.*

**Theme IV – Pivotal Points That Led to Feelings of Hopelessness**

***Stanley:*** *I was so heavy that chairs would break underneath me when I would sit down. I had that happen about three or four times. Ok, one time I was at a student's house working with them and the chair gave out under me. I mean, literally I was sitting there in the chair and it had been creaky before, but it just broke underneath me. I don't know that I was moving…it wasn't like I was sitting down into it and suddenly it just couldn't take the weight. Another time that is exactly what happened. I was at a mall with a food court and…..I don't have a perception that I dropped my weight into it, but I was very tired and I may have done exactly that. I may have just plopped down into the chair if you know what I mean, but I wasn't deliberately trying to crash myself into it. I have never set out to break a chair if you know what I'm saying. I have had a couple of other times where the chair began to give under me and I caught myself before going all the way down, but then I looked at it and it's like "whoops, there goes the weld on that spot".*

*I had one time at school….you know they have those folding metal chairs…not the metal back ones but the plastic back ones….I was sitting down in one of those and I felt the metal bar that connects with the rivets to the pipe…like a metal tube that makes up the legs?…..I was sitting down in one of those and I felt the rivet give out and I was able to keep myself from crashing and that was very embarrassing because I had to get up and fold the chair and move it and then I had to remain standing for the rest of the length of the presentation which ran over an hour which was extremely painful.*

*It was around this time that these kinds of things exacerbated the feelings I had of basically waiting to die. I wasn't suicidal but I had that apathy of just waiting to die. Stanley: It was just an apathy…it was like feeling that nothing was going to get better and I was simply waiting for it to keep getting worse.*

**Theme V - Previous Yoga Experience and Experience with DDP Yoga (Benefits of Practice)**

***Stanley:*** *I had been looking for some kind of program…I'd actually gone to a couple of local yoga studios and they turned me away. They said they did not have anyone there who could really work with me. So, I tried doing some things with some videos but I did not have….how do I put it…they just did not work for me. I was sort of tooling around the internet and you know how you just throw different things into a search engine to see what you're getting and I ended up typing in, "yoga and broken back" and I saw some links that took me to Dallas Page. One thing led to another and I found the YRG web site and I found the links to his YouTube videos, so I sat there and…on my computer…I followed them up and I did it also along with those minute long YouTube clips and I thought…"I can do this".*

***Stanley:*** *The other yoga schools…..what they told me at first….and actually they didn't want to give me the straight thing at first……what ended up happening was they said….Well… "We can't have you in a class" and I said "why" and they said "well we have waiver issues" so on and so forth. I said, "I can sign waivers". "We have liability issues"…that was the term and they were talking about waivers. I know about waivers. I see those issues at school. You know as a special educator, my kids go on special activities, we have to get a whole bunch of waivers so they can participate. It's like taking a medically fragile child on a field trip means we have to do extra waivers…so I know a little bit about that.*

***Stanley:*** *They ended up coming down and saying…"look, we just don't have anybody who knows how to work with you".*

***Stanley:*** *My previous yoga experience…I don't know if you can call it a school or not, but what happened was…a long….and this was a very long time ago when I was in the army…there was this one young lady who I was dating and she was an administrative specialist in another unit…..and the unit I was in had no females in it; it was a combat unit…there were no women. So, I consider myself very lucky that I even had a girlfriend, so what ended up happening was she got interested in yoga and the Morale Recreation and Welfare (MWR) program had this yoga class. It met in a room off of the library. So the library had these extra rooms that the MWR…it had sewing classes in them and German language classes in them and they had….they even had martial arts classes in some of these rooms. So they were like community rooms. Two or three times a week we would go up there and take the yoga classes. You would walk in there…drop 5 bucks in the box, sign your name to a sheet of paper and take the yoga class. It was a yoga class and this is back in the Richard Hittelman era.*

***Stanley:*** *In the 60's Richard Hittleman and these little 30 day yoga books…. This was in that era. In fact, that was the very first book I ever got on yoga because I wanted to read up a little bit about it because I knew there was something going on in my body from taking that class. So, that's what we did and I would go and take this yoga class a couple nights a week and the next day I remember always feeling better for having taken that class as I thought there is something going on here that is good and I just kind of filed that away…and I'll be honest. A little while later I stopped going, and that had to do with dating a different girl…which a long long long time ago before I met my wife, but that experience taught me that yoga could be useful to me and then when the*

*time came that I needed something like that, I had that memory and I thought well…I'll give this a try but the problem is….there's a huge difference between being an 18 year old paratrooper taking a yoga class and being an older guy taking yoga for pain management. I did not have the language for it then but I do now. I was adjusting my spine. What would happen would be when I was going in I would feel something move in my back. I was adjusting my vertebra back. At the time I didn't have the language to say that but now I know….that that's what was happening because I was adjusting my spine at a time when I really needed it. What I needed back then that I did not understand was that I needed to see a chiropractor several times a week and I wasn't; I was doing the yoga and that was helping me. I found something that was good for me back then, but I just did not realize…..it's like doing something good for yourself but not realizing it. I could start feeling what was going on in my spine almost immediately and I felt better.*

***Stanley:*** *The original DDP yoga DVDs talk about this position is doing this muscle and this position is doing this muscle and so on and so forth…and this is working your back and this is working that……Dallas comes from this idea that the position is not the be all end all. The position is a tool to get a certain part of the body to be working. I was able to go back and take that knowledge… and then my own skill set. I had to modify the positions and I had to use my unique skill set in order to allow me to figure out how to make that work for me. I had to learn to modify positions by applying my knowledge of accommodation and modifications.*

*I mean sometimes it took some figuring to find the accommodation and modifications that would allow me to access certain positions and in the learning process, I fell down a lot and I began to have some successes…and those successes encouraged me. Dallas told me when I first started, not to get on the scale every month…..I mean every day; he told me to get on it once a month. I stuck with that but I noticed that after two weeks, my pants were so much looser. I knew I was losing weight….how much weight I did not know.*

***Stanley:*** *I began to be aware of my own body again. For someone who had been outside their body for so long, it was an unusual experience to regain that body awareness; it was not something that I was expecting. I think this may have been an advantage I had…….I approached this program with minimal expectations.*

***Stanley:*** *I was not expecting……anything like this. I was extremely happy that I could breathe and move with less pain. My original motivation for getting in this program…..you know everybody talks about weight loss…and that's wonderful; I think it's fantastic. I love my weight loss, but what really excited me most about it was the pain.*

***Stanley:*** *The pain was subsiding. I was managing. One of the big things that I tell people about is that right now, my pain is at a level…..I mean it's not gone….I really wish I could tell people, "oh my pain is gone and I'm feeling glorious every single day all the time"; that would be a lie. The reality is my pain is still here. However, my pain is manageable. I mean, a couple of times a week, I have to take some Motrin for it (laughs). I mean compared to what I was….that is miraculous.*

***Stanley:*** *I mean I was at the point where they had me taking schedule I meds and it's amazing that I can manage what used to be just incapacitating pain.*

*If there is a real…….everyone says what happened to me is just miraculous and wonderful and yea rah, but if there is a miracle to this, it is that I am now able to live. That's what I have had to do to find those accommodations and modifications and again…that is my business…..is finding accommodation and modifications; finding ways to work around these issues. I think that that really….what's a good way to say this….that really has helped me immensely. Learning to find those accommodations and modifications. I think it has given me insights that I have been able to use across the spectrum in so many different aspects of my life.*

***Stanley:*** *I have learned not to give up; that's probably one of the most important things I have gotten from this practice….is that I am in control of so many aspects of my life and that what has happened to me and that what happens to me is not the controlling factor in my life. The controlling factor in my existence is not what has happened to me, but the decisions that I make…..and making those decisions….good or bad….living with the consequences of those decisions…again…good or bad… is what defines me as an individual; not what has happened. If I sit there and make my life about the injuries that have happened to me…the injustices that have happened to me then I will be missing out on opportunities….or take advantage of positive things that are right there in front of me.*
*My decision making is better as a result of taking DDP yoga and Stanley: it's more informed! It's not that my decision making was bad. It's that the perspective of making the decisions was inaccurate. If I had gotten out, and someone had been there to tell me, "look, you can recover from this. You need to change how you eat because you are no longer a young paratrooper, you're an old guy. You are no longer ruck sacking around the woods for 9 hours a day. You're at home working behind a desk." Nobody ever did. I needed to know that explicitly because my inferential skills were clouded. Now I know that better.*

**Theme VI – Increases in Mobility**
*I had the braces holding me up and I wasn't able to walk without them. Stanley: They came off a piece at a time. The first thing that I was able to get rid of was the back brace which was really a blessing. Then the leg braces came off a few months later. It's hard to tell how much at the end whether I got rid of the crutches as early as possible or not because I was in a school building at the time and maneuvering around the building on my own feet. When you have 2,000 kids in the building, you have to be able to move and pivot quickly….and there is a five minute period between classes and you have 2,000 kids going from place to place…so I might have been able to get rid of them. One thing I do know….I actually went one cane and then for a while I was experimenting in class. My kids actually saw this, that in class I was trying to be on one or no cane at all, but they knew that….I even told them, I said, "look, I am not going to do that always, just on two feet yet. I will…I made a point of saying I will do that, but it's not happening today. To a degree, they were involved. They saw the process. That class was with me for the process.*

**Theme VII – Vocational Implications**
*I'm a special educator. Now, when I look at my kids, I say, "What do they need to get done?", "What is their disability?", and "What do I need to do around that disability to get them to accomplish their task"? Same thing…..I cannot do certain things, but I want to work this muscle. How can I make this position something that I can access and still allow me to work that muscle. So I*

*had to modify the positions and I had to use my unique skill set in order to allow me to figure out how to make that work for me. I had to learn to modify positions by applying my knowledge of accommodation and modifications; that is my stock in trade…is modifying techniques in order to make them accessible to people with disabilities; well…I had to use it on myself. I had to take what I had been doing for other people for all this time. For a very long time I would always tell my students…"look, you may have a disabling condition but that condition does not define you". It is important for them to understand that having a disability does not mean that you are that disability. Now, here's the weird thing….I would always tell them that, but I had not really internalized that in my own case. I still treated myself as a disability rather than as a person with a disability. Working with Dallas, I realized that I needed to start treating myself the way I was telling my students to treat themselves. I had to tell myself that I was not a disability. I had to tell myself that I may have a disability but that my disability does not define me. It may limit my ability to perform certain tasks….I mean that's part of the definition of being disabled: you have a physical limitation, illness or injury or structural defect that impairs one or more major life functions….I mean that's our textbook definition of a disabled student. Now, I needed to take that knowledge…that skill set that I have and I had to apply it….and that was not always easy.*

*It's funny because now I look at it and I make it a big point about the fact that I applied the tools that I learned as a special educator, but I was not doing that at first…now I do that on a daily basis. I actually have written…..if I get a little jargony let me know….I have actually written my own IEP. I have written my own individual education plan, my own training improvement plan…I don't really call it an IEP but that's the language of a special educator……and like that….I stopped and I looked at levels…I looked at goals….I looked at standards….I looked at monitoring and assessment…..I looked at accommodation and modifications and I looked at all of that…and I still do in a lot of different areas. I had found….some measure of solace in my work as a special educator.*

*I teach kids and I had to bring that mindset to myself and it had not occurred to me to do that. You would think it would be a logical thing, but it was not. It is one of these things where having the…..what's a good way to say this…it's one of these things that having the mindset is what makes the difference. Having a mindset of, "I have this, I need that…whatever it is" makes that difference. Part of what allowed me to do this is the fact that I have this unstoppable G.I. work ethic. I was able to take that knowledge that I had and…..I mean one of my Masters Degrees is in Curriculum Design and Adaptation; that's kind of a standard thing with special educators, which is modifying and adapting curriculum to make everything fit.*

*I was able to use those ideas of, "How am I going to adapt this curriculum? How am I going to modify this?" It comes down to several ideas. "What is the point of an exercise?" Then, "What is my limitation and what is my limitation's impact on me performing that exercise?" Then the next question is, "What is the impact of my limitation on my ability to do what the exercise is designed to do?" Based on certain other parameters I may have to adapt the exercise, I may have to replace it with a similar exercise that is not impacted by my limitations or I may be able to do it with certain adaptations in terms of time, in terms of equipment. You know, Dallas (Diamond Dallas Page) says make it your own, so I was sitting there designing accommodations and modifications.*

***Stanley:*** *Once I came to the realization that that was something that I could do….and it's not a matter of…..I'm a person who is a strong believer in authority and I felt like, "Who am I to do this?" I have no academic credentialing that allows me to do this. At the time I was not a yoga teacher…. I am now…..but I thought at the time that it was not my place to be doing something like this…and then it occurred to me that there is someone else doing this and I need this done. Therefor credential or not, certified or not, I am going to start building my own stuff. I don't mean physically, I mean in terms of design. I'm going to start designing my own curriculum and that's what I started doing.*

**Theme VIII – Teaching DDP yoga and becoming a RYT.**

***Stanley:*** *I became certified in YRG…I was one of the first people outside of Dallas' immediate circle when he developed it…I was one of the first people outside of that circle to become certified as an instructor and I think part of that was the fact that I was doing it every single day and most days twice a day and I still do twice a day most days. I think a big part of it was the fact that I knew it and that I was learning….Dallas told me at a certain point that he wanted me to start practicing "calling it" and we were talking and he suggested that I look at certifying as a regular yoga teacher just to deepen out my practice. So I went to a local school that had a certification program and I started talking to them about that and it's kind of interesting because I went there when I was still on crutches and they took a leap of faith with me and I went down and did the 200 hour certification course and it was kind of a bizarre experience being on crutches in a room of extremely fit and extremely able people. On the flip side it was interesting to them because they were watching the weight pouring off of me.*

***Stanley:*** *There was a lot to do. There was this huge amount of study and the weird thing is, is that it was very much of a grad school experience because you meet and are expected to have done all the reading and all the studying on your own and you're not always told what you're looking for in the study…. you're just told, "read this, be prepared to discuss" and sometimes it's several books. You meet once or twice a month and it's a very intense meeting when you get there because…like I said everyone is expected to know all the material so it's very much of a grad school kind of experience. The flip side of it is that it's not only academic; it's also very physical so you are going through a lot. They expect the yoga teachers not only to have the physical development and the knowledge….. but one thing that caught me as very interesting was….they really wanted you to develop this very new age kind of mindset about things. The place where I went, we talked about the energetic body, we talked a lot about different cosmologies. A lot of ethics and morality about things that did not directly relate. They were trying to produce sort of a munchy-crunchy granola kind of yoga teacher. One thing that I was struck….we read the autobiography of the yogi, we read and discussed extensively the yoga sutras, we discussed Hatha Yoga Pradipika, we discussed parts of the Ramayan, we discussed Bhagavad Gita at depth and length, we discussed some Buddhist texts. We spent out of two hundred hours, maybe ten to fifteen on anatomy. Out of all that time and all that reading, we spent very little time on anatomy and I really put in a lot of time on my own outside of class and outside of the curriculum studying anatomy.*

**Stanley:** *I've come to view yoga as a technology. I've got my school teacher's definition of technology, "Systematic application of knowledge to problem solving". That's actually a high school textbook definition of technology and I find it a very useful one. Anyway, looking at it in those terms, yoga is a technology. I mean, people have been getting together and peer reviewing what they are doing for millennium. You cannot do something for that long….you cannot have an ongoing peer review process for that long without making certain conclusions. Looking at it from another way….in terms of it being a pure physical culture, not a fighting culture like the martial arts or the basic human act of walking and running which is locomotion or self- preservation….in terms of being an activity that is set for the express purpose of being healthy, yoga is the oldest form of physical culture that is continuously practiced….period.*

***Stanley:*** *Something does not last that long if it doesn't have some basic validity to it. So just looking at it from the pure simple bare bones commercial….I mean that in the literal sense….commercial, logic of it all, people would not invest time and money in something to become healthy if it did not work. I mean look at different exercise trends during our lifetime that have come and gone.*

## Analysis

### Theme I – Weight

Stanley's weight loss was clearly correlated with his participation in DDP yoga. As he mentioned, his primary motivation was not weight loss, though it appears his weight loss was a "byproduct" of his yoga practice. He imparted that he practices twice a day, so it is also apparent that his weight loss was correlated with the work that he is putting into his yoga practice. He also mentioned that his weight fluctuates naturally, though it is evident that he has lost enough weight that he is medically considered healthy for his height of 5 feet, 6 inches tall. Results of the interview also show a correlation between his increased mobility and his weight loss.

### Theme II – Injuries (Physical and Psychological)

Stanley's injuries were due to his years spent in the army as a para-trooper where he suffered many of his broken bones and spinal injuries. Inherent throughout, we see that his injuries were correlated with his depressed mood and feelings of hopelessness which then led to a passive suicidal ideation. No doubt the public embarrassment experienced due to no longer being able to fit in with "normal" society exacerbated these feelings and led to what could be described as a "breaking point"; the willingness to do anything to make the pain (physiological and psychological) go away. Instead of giving up, he found solace in his work as a special educator (a theme to be discussed later) and this is what led him to keep fighting.

### Theme III – Pain Management

The universal theme evident in Stanley's thread of pain management is that DDP yoga has helped him with spinal alignment and as a result, has enabled him to forgo much of the pain that was associated with his injuries. Certainly, the themes discussed in weight loss contributed to the reduction of pain in his joints, but it appears that the thread of spinal alignment (illustrated in theme V) is what led to increases in his mobility (illustrated in theme VI). These constructs are what correlated to the management of his once intolerable chronic pain through his DDP yoga practice.

### Theme IV – Pivotal Points That Led to Feelings of Hopelessness

Stanley's experiences with chairs breaking under him in public were the defining factor that led him to give up hope of any kind of normal life. When these incidents were happening on more than one occasion, the public embarrassment and internal humiliation that occurred were enough to put him in a state of despair to the point of him giving up on everything in his life. Aside from this element, Stanley was resigned to living the life of a man imprisoned by his own weight and was hoping to die in his sleep.

**Theme V - Previous Yoga Experience and Experience with DDP Yoga (Benefits of Practice)**

The first thing that we see happening with Stanley was that his pain was immediately subsiding as a result of practicing DDP yoga, to the point where it is now manageable. Where he was once turning into a zombie due to being on prescription medication and diagnosed as being palliative care, he was now merely taking Motrin a couple of times a week. Stanley also described that his first experience with yoga years ago in the army was enabling the alignment of his spine, and he stated that DDP yoga stresses the kinesthetic movements and limitations in ambulation of its practitioners more so than traditional schools of yoga do, and that this philosophy of practice enabled him to focus on spinal alignment. Thus, those with special needs are encouraged to adapt and modify the positions so that they can push themselves to their own limit and stay in their fat burning zone. Stanley stated that DDP yoga enabled him to be creative enough in his practice to modify the positions so that he could stay engaged enough to be working, but not discouraging him to the point where the positions were unfathomable.

Additionally, Stanley stated that his mindfulness of body was increasing. Furthermore, he stated that his weight loss was a byproduct for him as a result and that the pain was becoming immeasurably better. His decision making is more informed. As Stanley had mentioned, the benefits he found in his spinal alignment and the benefits this invariably had on his nervous system, led to a more direct and realistic sensory experience for him. Thus, he described his decision making as being less reactionary and more logical due to increased levels of cortical involvement; hence more informed and better decision making abilities.

**Theme VI – Increases in Mobility**

Stanley went from weighing 340 pounds, unable to sit up unassisted and unable to walk without the assistance of wraparound canes to being able to not only walk on his own, but run on his own, perform full splits, weigh 156 pounds and teach yoga as a result of his regular practice of DDP yoga. He was able to slowly and steadily walk without using the back brace, the leg braces and the canes over a period of months.

**Theme VII - Vocational Implications**

Stanley's vocation as a special educator in high school was the anchor throughout his dark times. He found solace in his profession when he was able to apply what he was teaching his students to himself. He was able to modify and adapt curricula for his classroom as he had learned to modify and adapt his DDP yoga positions. This was the beacon that allowed him to continue pushing forward despite all of the obstacles he was experiencing internally and externally. It was also the means to which he was able to even perform DDP yoga in the early stages based on his limited mobility. Unequivocally, this is what enabled him to perform DDP yoga. It is important to

note that this lack of expertise in other yoga instructors is what led them to turn Stanley away at the door. Stanley's insight in this area enabled him to reverse what he had been expert at for many years with his students and apply it to himself. It is evident that Stanley's career as a special educator significantly contributed to his transformation.

**Theme VIII – Teaching DDP yoga and becoming a RYT.**

The vocational implications previously discussed led Stanly to believe that not only could he perform DDP yoga, but that he could impart this skill to others, especially those with obesity issues and other special needs. This inspired him to become a Registered Yoga Teacher (RYT). In addition, he started teaching when he was still on crutches, so his students literally saw the weight coming off of him and his mobility increasing. Thus, he was serving as a model for these already physically fit and able people, to see that they could further themselves even beyond what they thought possible.

## Discussion

Stanley's perception of DDP yoga and himself transformed throughout his experience with the practice. His previous experience with traditional yoga schools turning him away led him to believe that there had to be another way to achieve his goals. This rejection served as a catalyst for his motivation toward internal and external transformation. Stanley's initial goal and motivation for the practice of DDP yoga morphed from simple pain management to a complete transformation in mood, problem solving ability, mobility, spinal alignment, weight loss, professional development, mindfulness, integration with community/family, meaning and quality of life. The first order themes ((a) the injuries sustained over his life, (b) the chronic pain as a result of those injuries, and (c) the feelings of helplessness, hopelessness, apathy and worthlessness) were all transformed into catalysts for personal growth in spite of the deleterious position he had found himself in before beginning DDP yoga. This in turn also led him to give back what he had received by becoming a teacher of the practice himself. DDP yoga facilitated Stanley's transformation and led him to overcome obesity, immobility, hopelessness, and low self-esteem. Consequently, Stanley has regained mobility, is excelling in his work, and is teaching the very lifestyle that led to his recovery and transformation.

**Limitations and Future Study**

This is a single qualitative case study. Therefore, it is difficult to generalize the results to other populations without replicating the study with more individuals. Future quantitative and/or qualitative studies and analysis may be beneficial if focused on DDP yoga practitioners with a history of various spinal injuries or other chronic pain. Utilizing a perception scale in relation to time spent practicing DDP yoga may also be beneficial to future studies.

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# Pharmacology Training of Counselors

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As the use of psychotropic medications to treat mental illness increases across the lifespan, the need for psychopharmacology training for counselors intensifies. Research by Sepulveda (2011) concluded that counselor educators are not overwhelmingly supportive of including a psychopharmacology course in CACREP–approved school counselor curricula. Expanding on Sepulveda's (2011) work, our findings indicate that most CACREP-approved counseling programs do not offer psychological or psychopharmacology courses. Most program directors favor such courses in their programs, and agree that licensed counselors are routinely confronted with medication issues in professional settings. But despite the fact that most programs lack training in psychopharmacology, directors believe their graduates are sufficiently trained. We found ongoing evidence to support Sepulveda's (2011) conclusion that the need for psychopharmacology training exceeds available training.

*Keywords*: School Counselors, Psychopharmacology, Psychiatric Medications, Children

According to Kaut and Dickinson (2007), mental health counselors are routinely confronted with medication issues in clinical practice; for most clients, medication and psychotherapy are considered the standard of care (King & Anderson, 2004). For many clients, the use of psychotropic medications begins in childhood. Ten percent to 12.5 % of children between the ages of five and 15 meet diagnostic criteria for a psychiatric disorder (Meltzer, 2007; Merikangas, He, Brody, Fisher, Bourdon & Koretz, 2009), and 13.1 % of children aged eight to 15, as well as 46 % of adolescents, have a lifetime risk of having a psychiatric illness (National Institute of Mental Health, 2012). School–aged children are being treated with psychiatric medications for a range of problems; including, Attention–deficit/hyperactivity disorder (ADHD), mood disorders, Conduct disorder, Panic or Generalized anxiety disorder, and eating disorders (James & Nims, 1996; Mark, 2010; Meltzer, 2007; Merikangas et al., 2009; National Institute of Mental Health, 2012; Ryan, Katsiyannis, Losinski, Reid & Ellis, 2014). These treatments are likely to continue, given that adults diagnosed with psychotic and mood disorders are also treated with psychotropic medications (Keltner & Folks, 2001). Therefore, the use of psychotropic medications across the lifespan exposes mental health counselors in all settings to issues related to their use.

One particular mental health issue involves the potential treatment–emergent adverse events that accompany many of the medications used to treat mental disorders (James & Nims, 1996). For example, lisdexamfetamine (Vyvanse), used to treat ADHD, includes common side effects of decreased appetite, headache, insomnia, decreased weight, and irritability (Findling, et al., 2011). Additionally, side effects including headache, somnolence, and increased appetite are frequently associated with taking risperidone (Risperdal) in the

treatment of severe disruptive disorders in children with low to below average intelligence (Findling, Aman, Eerdekens, Derivan, & Lyons, 2004). While these medications can improve behavior and focus, in some individuals, the adverse side effects can interfere with success at home and at school. For example, Risperadol may improve agitation, but it may also cause sedation and dampen cognitive function. Additionally, sexual dysfunction, changes in appetite, agitation, suicidal ideations, and insomnia are often experienced by adults taking psychotropic medications (Keltner & Folks, 2001). These adverse side effects in and of themselves can create issues (e.g., non–compliance or relationship issues) that mental health counselors are routinely addressing in their day–to–day work.

In response to the increased use of medications in mental health treatment, the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) created standards requiring the inclusion of psychopharmacology content in Clinical Mental Health Counseling (CMHC), Addiction Counseling (AC), and Marriage and Family Counseling (MFC) programs in order to better educate counselors on training about issues related to psychotropic medication use. In an attempt to better understand factors that predicted whether psychopharmacology courses were offered in CACREP counseling programs, Sepulveda (2011) surveyed counselor educators. Sepulveda (2011) concluded that courses were more likely to be offered if counselor educators had training in psychopharmacology, were from a North Atlantic or Western geographic region, and perceived a need for psychopharmacology training. Although a large percentage (91.1%) of programs surveyed included at least some discussion of psychopharmacology in courses, less than half of those surveyed (40.6%) offered a stand–alone psychopharmacology course. Sepulveda (2011) also noted, however, that while counselor educators saw a pressing need for CMHC, AC, and MFC counseling students to have psychopharmacology classes, they were not overwhelmingly in favor of offering these courses to school counseling students. In a presentation of the study, Sepulveda and Piazza (2011) concluded the perceived need for training exceeds the availability of psychopharmacology coursework, that training through continuing education would not suffice, and that on–the–job training was expected.

With the increased use of psychotropic medication across the lifespan, research is needed to determine whether the inclusion of psychopharmacology standards has resulted in counselors being adequately trained to handle these issues. The current study replicates Sepulveda's (2011) study of psychopharmacology course offerings in CACREP programs and of counselor educators' views concerning how well students are trained in psychopharmacology.

The current study was guided by the following research questions:

(1) How many CACREP counseling programs either require a psychopharmacology course in their curriculum or offer it as an elective?

(2) What are the potential obstacles to offering psychopharmacology courses?

(3) Do program directors believe that licensed counselors are working in settings in which they are routinely confronted with psychopharmacology issues?

(4) Do program directors believe that counselors graduating from their programs receive adequate psychopharmacology training?

(5) Do program directors agree that psychopharmacology courses be required?

(6) Do program directors believe that psychopharmacology training is lacking in most CACREP programs?

(7) Are program directors more likely to agree that a psychopharmacology course be required if graduates from their respective programs completed this course?

(8) Has there been an increase in the number psychopharmacology course offerings in CACREP programs since 2009?

(9) Have program directors' attitudes toward requiring psychopharmacology courses changed since 2009?

## Method

### Participants

Participants were a convenience sample of 57 program directors of CACREP–accredited counseling programs. Using the directory of CACREP programs listed on www.cacrep.org, 279 universities were identified as offering at least one CACREP–approved counseling program. Of these universities listed, contact information (i.e., an email address) for 179 program directors (64.9% of universities) was provided in the directory. In the second week of February 2012, initial recruitment emails were sent to program directors asking them to complete an online survey (www.kwiksurvey.com). The survey was designed to evaluate attitudes and beliefs on psychopharmacology course offerings in CACREP programs, with a follow–up email sent 7 days later. This initial recruitment yielded a 13% response rate (N = 24 online surveys).

In an attempt to increase response rate, the remaining 155 program directors were sent a recruitment letter a month later that included a consent form, questionnaire, self–addressed stamped envelope, and a $1 bill. As an incentive, a $100 gift certificate was given to one randomly chosen participant who returned the survey by May 15, 2012. Thirty–four paper questionnaires were returned via mail, increasing the response rate to 32% (N= 56 total surveys), as 2 surveys were not completed correctly and therefore excluded from the data analysis.

### Research Design and Procedures

Because the current study aimed to replicate and extend a previous questionnaire used to evaluate psychopharmacology instruction in counseling programs (Sepulveda, 2011), a 71– item survey was created titled "Psychopharmacology Curriculum in CACREP Accredited Counseling Programs: A Survey of Program Liaisons." The survey was divided into the following 4 sections: (a) program director demographics, (b) program demographics, (c) attitudes toward offering psychopharmacology courses in a CACREP counseling curriculum, and (d) attitudes toward counselors' need for increased knowledge of psychopharmacology. The term psychopharmacology was defined at the beginning of the questionnaire as the area of pharmacology that is related to the psychological effects of drugs and the use of drugs to treat symptoms of mental and emotional disorders (Ingersoll & Rak, 2006).

Participants were first asked to answer 9 questions regarding their training background and current practice activities. Next, they answered 23 questions related to their CACREP counseling programs, including type of CACREP accredited programs offered, degrees offered, and whether psychopharmacology courses were offered either as an elective or requirement. For both required and elective courses, participants were

asked to identify any obstacles that occurred when adding the psychopharmacology course to the curriculum. Participants were also asked which counselor work settings were confronted with psychopharmacology issues and whether or not they believed that graduates from their programs were sufficiently trained in psychopharmacology.

Participants next completed a series of 37 five–point Likert scale items to assess program directors' attitudes toward psychopharmacology courses included in CACREP programs as well as counselor understanding and use of psychopharmacology information in the counseling process.

Participants represented 150 different counseling specialty programs across 56 university departments (see Table 1). The vast majority of programs (81%) were accredited according to the 2009 CACREP standards, while the remaining (22%) were accredited according to the 2001 standards. Almost all participants (98%) earned a doctoral degree in either counselor education (63%) or counseling psychology (24%). Most programs provided (89.0%) master degrees while the remaining (11.0%) were doctoral. There were five (3.0%) programs that offered both masters and doctoral counseling degrees. A majority of participants identified themselves as being a Licensed Professional Counselor (LPC). Participants were mostly employed by departments offering master's degrees in school counseling (30%) or clinical mental health (23%). Approximately 55% of participants were not working in a private practice setting. Slightly more than half of participants (54%) had no prior psychopharmacology training, whereas some completed a required course (18%), at least one continuing education course (16%), or an elective course (10%). A small percentage (2%) completed a graduate degree in psychopharmacology.

**Data Analysis**

To answer the first six research questions, the percentage of program directors' responses to specific items on the survey questionnaire was analyzed. Next, a Fisher's Exact Probability Test was performed to examine the relationship between having a psychopharmacology course in the program directors' curricula and their attitudes toward requiring this course in CACREP programs. A chi–square test for goodness of fit was performed to examine whether or not there has been an increase in the number of CACREP programs offering a psychopharmacology course since 2009. Finally, a Test for Significance of a Difference Between Two Proportions (TSDBTP) was calculated to investigate whether or not program directors' attitudes toward requiring a psychopharmacology course in CACREP programs has changed since 2009 (Sepulveda, 2011).

## Results

**Research Questions**

**Research question 1.** *How many CACREP counseling programs either require a psychopharmacology course in their curriculum or offer it as an elective?*

Out of 56 different departments, 44% (N = 25) offered a psychopharmacology course while 54% (N = 31) did not. Most departments offered multiple CACREP counseling specialty programs, but not all programs required a psychopharmacology course. Of those 25 departments with a psychopharmacology course being taught, 60% (N = 15) of the departments required the course across 19 different counseling degree programs. The remaining 40% (N = 10)

of the departments listed psychopharmacology as an elective course across 14 counseling degree programs. Psychopharmacology courses were typically offered within the counseling department (88%). One participant indicated the course was available in either the counseling or the nursing department, while two participants reported it was offered in a psychology department.

***Research question 2****. What are the potential obstacles to offering psychopharmacology courses?*

Of the 25 participants from departments that either required or offered a psychopharmacology course, 56% (N = 14) endorsed having no obstacles to offering the course. The most frequently reported obstacle was related to having limited or no access to qualified faculty available to teach such a specialized course. Lack of faculty interest in the subject matter was not identified as being an obstacle.

Of the 31 participants from departments not offering a psychopharmacology course, the vast majority (97%) reported having obstacles that prevented offering the course. More specifically, having to sacrifice another course was the most common reported obstacle (77%) followed by lack of qualified faculty (32%) and lack of faculty interest in the subject (25%). On average, most (71%) participants believed that their programs were unlikely or very unlikely to offer a psychopharmacology course in the future.

**Research question 3.** *Do program directors believe that licensed counselors are working in settings in which they are routinely confronted with psychopharmacology issues?*

Participants were asked whether they believe that licensed counselors working in any of 7 practice areas of counseling (i.e., addictions, career, clinical mental health, counselor education/supervision, marriage & family, school, and student affairs/college) are routinely confronted with medication issues in their work setting. All participants (N = 57) agreed that counselors working in clinical mental health are routinely confronted with these issues. The majority of participants also agreed that counselors working in the areas of addiction (96%), marriage & family (73%), school (77%), and student affairs & college (61%) counseling are also routinely dealing with medication issues. A little more than half (56%) of participants believed that counselor educators/supervisors deal with these issues. Most participants (72%) believed, however, that psychopharmacology issues were not a common issue in career counseling settings.

**Research question 4.** *Do program directors believe that counselors graduating from their programs receive adequate psychopharmacology training?*

Participants were next asked whether graduates from their respective counseling programs received adequate training in psychopharmacology. Most participants reported that graduates from clinical mental health (74%) and mental health counseling (82%) were adequately trained. The sample included only one participant representing a student affairs program and one representing a Gerontological program. In both cases, the participants indicated that graduates were sufficiently trained in psychopharmacology, even though a course was not required or offered in either program. Most participants indicated that graduates from school (84%) and marriage & family (73%) counseling programs were not sufficiently trained. The 4 participants representing student affairs/college as well as the 4 representing college

counseling indicated their graduates were not well trained (see Table 1).

**Research question 6.** *Do program directors believe that psychopharmacology training is lacking in most CACREP programs?*

Regardless of specialty, 62% of participants agreed (strongly agree/agree) that psychopharmacology courses are lacking in CACREP programs. Approximately 23% disagreed (disagree/strongly disagree), while 9% remained neutral. Participants were more likely to agree or strongly agree that training is lacking within each specialty, with the exception of those from student affairs/college counseling and student affairs programs. The four participants from student affairs/college counseling were equally likely to agree or remain neutral.

**Research question 7.** *Are program directors more likely to agree that a psychopharmacology course should be required if graduates from their respective programs completed this course?*

Participants from departments that offered a psychopharmacology course (required or elective) were compared to those from departments who did not offer a course. Participants were separated into one of four groups based on (a) whether or not their programs offered a psychopharmacology course and (b) whether or not they indicated strongly agree/agree or strongly disagree/disagree on a single 5–point Likert scale item ("A psychopharmacology course should be required in all counselor education curricula"). A Fisher's Exact Probability Test examining the relationship between having a psychopharmacology course as part of the curriculum and participants' belief that such a course be required in counseling curricula was significant $p = 0.02$.

**Research question 8.** *Has there been an increase in the number of psychopharmacology course offerings in CACREP programs offering a since 2009 (Sepulveda, 2011)?*

Previously, Sepulveda (2011) found that 41% of 101 program directors reported their programs offered a psychopharmacology course in 2009, while 44% of the 56 participants in the current study represented programs that either required or offered a course as an elective. A chi–square test for goodness of fit examining whether or not the number of CACREP programs offering a psychopharmacology course since 2009 has increased was not significant ($x2(1, 56) = 0.17$, $p = 0.68$).

**Research question 9.** *Have program directors' attitudes toward requiring a psychopharmacology course in counseling curricula changed since 2009 (Sepulveda, 2011)?*

When asked to rate their level of agreement that CACREP should require a psychopharmacology course in counselor education programs ("I believe graduate students in counselor education programs should take at least one course in which psychopharmacology is the primary subject matter."), Sepulveda (2011) found that 60% (N = 56) of program directors strongly disagreed/disagreed while the remaining 40% (N = 38) agreed/strongly agreed. Unlike Sepulveda, the current survey included a "neutral" option, which was chosen by 24% (N =13) of participants. The remaining 42 out of 55 participants in the current study answered either agree/strongly agree or disagree/strongly disagree when asked a similar question ("A psychopharmacology course should be required in all counselor education curricula."). Those answering neutral were not included in further analysis. Approximately 40% (N = 17) of participants strongly

disagreed/disagreed while 60% (N = 25) agreed/strongly agreed that such a course be required. The 20%–point difference between the participants in the 2009 sample and the current sample who agreed that a psychopharmacology course be required was statistically significant, $z = 2.064$, $p = .039$.

## Discussion

Medication has become a common intervention to treat many child, adolescent, and adult psychiatric symptoms and disruptive behaviors. It is therefore not surprising to find that counselors commonly work with clients of all ages who are taking psychiatric medication. The importance of gaining knowledge of psychiatric medications and how they impact the counseling process is reflected in CACREP's requirement that psychopharmacology courses be included in Clinical Mental Health Counseling (CMHC), Addiction Counseling (AC), and Marriage and Family Counseling (MFC). The current study aimed to replicate and extend Sepulveda's (2011) research that surveyed CACREP programs to determine the extent to which psychopharmacology courses are included in accredited counseling curricula.

The current study found most departments that offered CACREP approved counseling programs did not offer a psychopharmacology course. When a course was offered, however, the majority of programs required rather than offered the course as an elective. The vast majority of the psychopharmacology courses were offered in the counseling department. For the departments that offered a course, just under half indicated that lack of qualified faculty to teach the course was an obstacle. For departments not offering the course, the overwhelming majority reported obstacles to offering the course, namely having to sacrifice an existing course.

In keeping with previous findings (Kaut & Dickinson, 2007; Sepulveda, 2011), we found that program directors believe that graduates of most CACREP counseling programs routinely encounter medication issues in their work setting. Although most programs do not offer a psychopharmacology course, most program directors believed that psychopharmacology training is lacking in most CACREP programs. Yet, with the exception of marriage and family counseling, school counseling, and student affairs/college counseling, most program directors believed their graduates were sufficiently trained in psychopharmacology. Similar to previous research in this area (Schaefer & Wong–Wylie, 2008; Scovel, Christensen, & England, 2002) but unlike others (Kaut & Dickinson, 2007), we found that most program directors favored including psychopharmacology courses into counseling curricula, yet most programs do not.

We found a strong positive relationship between directors' attitudes toward psychopharmacology courses being required and whether or not such courses are offered in their programs. Program directors were approximately three times more likely to agree that a psychopharmacology course be required if they were associated with programs that required or offered a course as an elective. This supports previous findings (Sepulveda, 2011) that program director's perception that psychopharmacology training is needed strongly predicted whether a psychopharmacology course was actually offered.

Our findings also support Sepulveda and Piazza's (2011) conclusion that the need for training exceeds available training. This is clearly illustrated in the current study's finding that 77% of program directors in school counseling

believe their graduates are routinely confronted with medication issues in the work setting, yet 97% of programs do not offer a psychopharmacology course, and only 20% of program directors believe graduates receive adequate training in this area. This is concerning given recent findings that there has been a significant increase in the use of psychotropic medications with school–aged children (James & Nims, 1996; Mark, 2010; Meltzer, 2007; Merikangas, et al., 2009; National Institute of Mental Health, 2012; Ryan, Katsiyannis, Losinski, Reid & Ellis, 2014). Similarly, 74% of program directors from Marriage and Family counseling report graduates are confronted with these issues in the work setting, 82% of programs do not offer a course, and only 27% believe graduates are adequately training. This is particularly concerning considering knowledge of psychopharmacology training is a required CACREP standard for Marriage and Family Counseling programs.

Program directors' attitudes towards psychopharmacology seem to be changing, but this has not translated into an increase in psychopharmacology courses being offered in counseling curricula. While attitudes toward requiring a psychopharmacology course have become more favorable since 2009, the number of psychopharmacology course has remained relatively stagnant in that same amount of time. It is possible that this stagnation of courses is due to perceived obstacles (e.g., would have to delete another course, no qualified teachers, lack of faculty interest) as well as CACREP standards only requiring psychopharmacology knowledge in three of eight specialty areas. Unfortunately, the lack of increase in psychopharmacology courses will only further prohibit counselors in training from receiving adequate preparation to handle medication issues in clinical practice (Kaut & Dickson, 2007; King & Anderson, 20014).

**Applications for Practice**

Overall, the number of programs offering psychopharmacology programs and program directors' attitudes toward including psychopharmacology courses in CACREP curriculum has not changed significantly since 2009, despite CACREP standards that require a basic knowledge of psychotropic medications for graduates of CMHC, AC, and MFC programs. Moreover, graduates of school and college counseling programs (without similar CACREP requirements) routinely encounter psychotropic medication issues with their clients (Kaut & Dickinson, 2007; King & Anderson, 2004). The current study suggests that basic psychopharmacology knowledge may need to be included as part of accreditation standards for all CACREP–accredited programs, including school counseling, as the research shows that a growing number of school–aged children are diagnosed with mental disorders that require the use of psychiatric medications (Meltzer, 2007, Merikangas, et al, 2009), and graduates from school counseling programs would benefit from a psychopharmacology course.

Undoubtedly, such coursework would better prepare counselors to address medication issues with the children they counsel and the teachers with whom they collaborate (James & Nims, 1996, Ryan, Katsiyannis, Losinski, Reid & Ellis, 2014). Additionally, efforts aimed at changing program directors' perceptions of this issue are needed; these may need to include addressing perceived obstacles, such as developing innovative ways to include a course without having to sacrifice others and hiring faculty who

are capable of teaching psychopharmacology.

**Limitations**

One limitation of this study is the small sample size and low response rate (N = 58; 32%), which was much less than that of Sepulveda's (2011) study (N = 101; 43%). Another limitation is that the sample was over represented (30%) by school counseling program directors, and as such generalizing findings to directors from other counseling specialties should be done cautiously. Future studies should consider replicating these findings with a more robust sample size that is equally representative of all counseling specialties. Additionally, research is needed on how commonly newly licensed counselors encounter medication issues in the work setting, their perceived need for training, actual level of psychopharmacology knowledge, and competency in dealing with medication issues as they arise in counseling (see Kaut & Dickinson, 2007, King & Anderson, 2004). It would also be interesting to know clients' perceptions of how effective their counselor is at handling psychopharmacology issues. Finally, studies should examine how these variables may impact the counseling processes and eventual outcomes. For example, are counselors who are perceived by clients to be more knowledgeable about medication issues also more likely to perceived as more effective counselors than those who are less knowledgeable?

**Conclusion**

It is not uncommon for counselors to work with clients who, in addition to counseling, rely on medications to improve their mental health. Because of this, it was not surprising to find that program directors in the current study generally agree that counselors are routinely faced with medication issues in most work settings. Despite this, only about half of the CACREP programs surveyed actually include a psychopharmacology course in their curriculum. This lack of coursework was clearly reflected in school counseling or marriage & family program directors' perceptions that their graduates are not adequately trained in psychopharmacology. Overall, program directors' attitudes toward including a psychopharmacology course seems to have become more positive since 2009, yet the number of programs including such a course during that same amount of time has not increased. These findings, like those of Sepulveda (2011), underscore the ongoing disconnect between counseling students need for more psychopharmacology training and the lack available training in CACREP curricula.

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Table 1

*Number of CACREP degree programs offering a psychopharmacology course and program directors' perceptions of sufficient training in psychopharmacology by specialty*

| Counseling specialties across 56 departments | # of Degree Programs (N = 150) across 56 departments | # of Degree Programs without a course * | # of Degree Programs with a course * | # of Degree Programs offering sufficient training* | Strongly Agree/Agree A course should be required* |
|---|---|---|---|---|---|
| Addiction | 5 (3.32%) | 3 (60.0%) | 2 (40.0%) | 3 (60.0%) | 3 (60.0%) |
| Career | 5 (3.3%) | 4 (80.0%) | 1 (20.0%) | 3 (60.0%) | 3 (60.0%) |
| Clinical Mental Health | 34 (23%) | 23 (68.0%) | 11 (32.0%) | 25 (74.0%) | 18 (56.2%) |
| Counselor Ed/Supervision | 16 (11%) | 14 (87.5%) | 2 (12.5%) | 9 (56.0%) | 6 (40.0%) |
| Marriage & Family | 11 (7.0%) | 9 (82.0%) | 2 (18.0%) | 3 (27.0%) | 5 (50.0%) |
| School Counseling | 45 (30%) | 44 (97.0%) | 3 (6.6%) | 9 (20.0%) | 20 (45.4%) |
| Student Affairs & College Counseling | 4 (2.7%) | 4 (100.0%) | 0 (0.0%) | 0 (0.0%) | 0 (00.0%) |
| Student Affairs (2001) | 1 (0.6%) | 1 (100.0%) | 0 (0.0%) | 1 (100%) | 1(100%) |
| College Counseling (2001) | 4 (2.7%) | 4 (100.0%) | 0 (0.0%) | 0 (0.0%) | 2 (50.0%) |
| Mental Health Counseling (2001) | 11 (7.0%) | 5 (45.4%) | 6 (54.5%) | 9 (82.0%) | 6 (54.5%) |
| Community Counseling (2001) | 15 (10%) | 10 (62.5%) | 6 (37.5%) | 10 (62.5%) | 6 (40.0%) |
| Gerontological Counseling (2001) | 1 (0.6%) | 1 (100.0%) | 0 (0.0%) | 1 (100.0%) | 1(100%) |

Note. * % based on total number of programs within a specialty

# Productivity-Focused Counseling

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Productivity-Focused Counseling (PFC) is a streamlined, unstructured approach to counseling that is based on therapeutic principles of Solution-Focused Brief Therapy (SFBT) and Rational-Emotive Behavioral Therapy (REBT) and educational principles of constructivist ways of thinking and knowing. While McKergrow and Korman (2009) expressed the view that the use of SFBT techniques may be inadequate out of the SFBT context, a discussion will be provided on how to integrate a modified version of the SFBT framework without the techniques. This article is an overview of Productivity-focused counseling, including discussions of its historical context and its view of human nature. The author will then discuss rationale, applications and target populations, and empirical support for PFC. Additionally, principles, key concepts, and techniques for PFC will be examined. Cultural and spiritual concerns related to PFC will be reviewed, concluding with measures of efficacy for PFC.

**Historical Context**

A specific client interaction created a necessity for more productive and organized ways of thinking and communicating in the therapeutic environment. The following scenario inspired the conceptualization of PFC:

*I once had a client who wanted to decide on a college major. However, he had trouble seeing one aspect of the problem at a time. I helped him narrow down his college major choices to three. At that point, I began facilitating his thinking about pros and cons of each of the three choices. As we discussed the pros and cons, I noticed he had trouble seeing the pro of a particular choice without the context of other choices. He would list a pro or a con and immediately say something to the tune of "yes, but what about this other choice?" rather than staying with the thought process of the individual implications of one possible individual choice. I found myself redirecting him to stay with a particular thought process so that it could be resolved before moving on.*

The above interplay instigated the development of a redirection concentration of clients' multifaceted concerns. Subsequently, the author began to apply the "on track" concept to other clients, and soon discovered the need to determine "which track?"

**View of Human Nature**

The view of human nature in PFC is neutral. Like REBT, PFC is an anti-deterministic perspective, where humans have the freedom to create their own destiny. PFC is consistent with the SFBT principle that the counselor refrain from use of "theories

to understand what is going wrong in the client's life" (McKergow & Korman, 2009, p. 38).

Productivity-focused counseling is atheoretical in its view of client issues, operating under the assumption that while many problems are universal, the specifics are unique to the individual. This view stands in stark contrast to developmental perspectives such as the Freudian view that human nature is driven by sex and aggression or the Adlerian emphasis on birth order as an explanation of behavior. These explanations may arise when conceptualizing the client's issues, but the PFC therapist is open to many interpretations of client issues. For example, a therapist who sees all client issues through the lens of birth order and actively pursues information related only to birth order would be confined to one theoretical application. A theoretical framework of client issues is certainly valid, but it is not consistent with PFC.

**Rationale for Productivity-Focused Counseling**

REBT and SFBT have been broadly identified as pragmatic approaches that were designed with efficiency in mind (Ellis & Ellis, 2011; Steenbarger, 2012). Despite this emphasis, authors of these approaches review productive counselor behaviors and associated positive outcomes, but neglect to give a well-defined outline of therapeutic productivity. Therefore, the major objective of this article is to clarify the parameters of therapeutic productivity that provide the theoretical framework from which to practice PFC.

**Specific Client Concerns and Target Populations**

Productivity-Focused Counseling was created as an effective means of working with verbose clients who generate a high quantity of content during the session. When working with digressive clients, the counselor's intention is to focus and redirect the client as necessary to generate optimally productive dialogue. The utility of PFC is especially maximized with these clients when the number of issues increases. In particular, PFC is geared toward clients who implicitly or explicitly express that they "don't know where to begin." For clients who are less talkative, the counselor uses questioning to instigate content generation (see Key Techniques).

Though PFC draws principles from REBT, SFBT, and constructivism, the author sees PFC as a broad theory. Its principles can be easily applied to many other theories. Although REBT techniques are a natural, consistent fit with PFC principles, other sets of approaches can substitute for the REBT techniques while still adhering to the theoretical framework of therapeutic productivity.

**Empirical Support for Productivity-Focused Counseling**

Research is not yet available to support PFC applications, specifically the assumptions of the parameters of therapeutic productivity offered in "Key Concepts." However, REBT basic components have been extensively studied. Solomon, Hagaa, Brody, Kirk, and Friedman (1998) found that people who had been diagnosed with major depression were more susceptible to negative mood states triggered by irrational beliefs than non-depressed people. As REBT works to dispute such irrational beliefs, these results suggest that REBT would be effective in treating major depression. In addition to changing irrational beliefs, Szentagotai (2008) found that REBT was effective in changing automatic thoughts and reducing depressed mood.

## Principles

PFC includes a collection of borrowed principles from SF, REBT, and constructivist theories to drive the practice of productive counseling. With an emphasis on principles of the current mode, the PFC counselor flexibly holds all PFC principles inclusive, regardless of mode.

The PFC counselor may work with the client in a similar way to how a constructivist supervisor might work with a supervisee. The relationship is egalitarian while acknowledging that time within the session is valuable. It is imperative that this time be used wisely. A collaborative evaluation of what will be productive in the session is predetermined.

***Solution-focused principles:***

- The counselor's listening method is guided by the client's presenting concerns (Bliss & Bray, 2009).
- If a strategy works continue using it and where a particular strategy is ineffective, employ a different technique (Bliss & Bray, 2009).
- The counselors function is to enable clients to determine their own destiny (Bliss & Bray, 2009).
- A minimalist approach is applied to therapy where the counselor focuses on and encourages only the content that will be useful to successful outcomes (Bliss & Bray, 2009; McKergow & Korman, 2009).

***Rational-emotive principles:***

- People are capable of both rational and irrational ways of thinking.
- The goal of striving for self-esteem is rejected in favor of achieving self-acceptance.
- People are responsible for their own happiness. Other people or external forces are not expected to behave in the way we wish at all times.
- A practical approach is applied to therapy.

***Constructivist principles:***

- Knowledge is socially constructed (McAuliffe & Lovell, 2006).
- Relativistic thought is valued over dualistic thought (McAuliffe & Lovell, 2006).
- A collaborative approach is applied (McAuliffe & Lovell, 2006).

***Principles unique to Productivity-Focused Counseling:***

- Productive client-generated content fosters productive therapy.
- It is the counselor's responsibility to help the client find focus and generate optimally productive content.
- The desired change may not necessarily take place in every therapeutic relationship, but productive changes are still likely to occur.
- A pure micro- or pure macro-level focus is only useful for so long. Looking only at the "big picture" at some points and only at the minutiae during others bypasses the opportunity to see the important detail offered by a meso-level focus.
- Gentle and respectful encouragement fosters the counselor-client relationship, as it shows that the

counselor is invested in the therapeutic process.

## Key Concepts

### Productive content

The PFC counselor sees counseling through the lens of therapeutic productivity**.** The author proposes an overarching definition of therapeutically productive content, which is: "narrative structures generated within the session that help the client work toward any specified or non-specified positive change." While this broad definition will be better articulated with further development, the author offers examples to clarify what is meant by productive content. Specifically, productive content will meet one or more of the following criteria:

*Facilitate client-reported desires.* Clients may clearly express what they want, and they may explicitly express what they believe is productive during therapy. If these desires are ethically and legally appropriate, the PFC counselor honors these goals and holds the client accountable for staying consistent with and evaluating these outcomes.

*Follow productive avenues.* Clients may have a variety of issues they wish to address in therapy. Through distillative summarizing (see "Key Techniques"), the PFC counselor helps the client to conceptualize each concern individually to form a workable avenue or track. A defining principle of PFC is the awareness that not all client issues will be solved, but if these productive avenues are followed, some positive change is likely to occur.

*Promote client self-improvement.* Self-improvement is unique to each client. Self-improvement may include changing thoughts, feelings, beliefs, or behaviors that lead to positive outcomes as defined by the client. Encouraging these changes is the goal of the productively-focused counselor.

### Unproductive content.

*Complaining.* Clients sometimes approach therapy as a podium for complaining, which might be framed as venting. The PFC assumption on this idea is that some venting can help the client feel better, but is not a good use of time in the session for the client to repeatedly vocalize the problem without adding further clarity. Therefore, the PFC counselor works to gently reduce complaining without discouraging content generation.

*Content that is unrelated to the presenting problem(s).* Some unrelated content might be related, but it is difficult to know whether this is the case. In PFC, the counselor helps the client construct a unique framework of possible avenues of discussion to work toward the problem. Once this unique framework is established, the counselor's job is to hold the client accountable for remaining on the therapeutic track.

*Small talk.* Discussions of the weather, results of a recent sporting event, and other light discussion that requires no critical thinking or feeling will be gently redirected by the PFC counselor.

*Ruminating and rehashing.* Once an insight or solution is well established, repetition of its content is unproductive.

*Unnecessary detail.* Content may become unproductive when unnecessary detail distracts from understanding the story or inhibits the client's ability to achieve what they desire from the therapeutic relationship. This criterion highlights the principle that a pure micro-level focus is not always effective.

*Addressing multiple concerns simultaneously.* Some clients become so overwhelmed by the totality of their problems that they fail to see beyond the macro-level. Addressing too many

concerns simultaneously becomes unproductive when the noise-levels of the individual issues become too loud. To make concerns more audible, the volume must be turned down. The PFC counselor supports the client's focus on a one concern at one time.

**Key Techniques**

The techniques of SFBT and REBT are discussed extensively by other authors. An overview of PFC specific techniques will be presented here. PFC is designed with focusing in mind. A key principle of PFC is that the counselor is responsible for directing client productive content. The counselor discerns what content is productive and what language is therapeutically useful.

To determine what topics are productive, the counselor makes note of which themes consistently surface in the client's narrative. These reemerging themes may not seem productive initially; therefore it is the counselor's responsibility to transform the topic into a productive one. For example, the client may tell and retell the same story about her ex-partner. This repetition allows the counselor to discover important details missed in the original version. Perhaps the counselor was unaware that the lost relationship was last time the client was happy. In this regard, resolution of the theme enhances productivity of treatment.

**Instinctive focusing techniques.**

Focusing techniques are used to gently nudge the client away from sustaining unproductive content and toward generating productive content. Four focusing techniques characteristic of PFC include: 1) Redirecting to the client or presenting problem, 2) Restorative/Distillative summarizing, 3) Addressing a limited number (usually one) of concerns at one time, and 4) Hearkening back to earlier keywords.

*Redirecting to the client or presenting problem***.** When the client veers from productive avenues, a gentle redirection is necessary to maintain productivity. Often people in therapy will discuss the external world, which is usually (but not always) unproductive. The PFC-oriented counselor actively looks for opportunities to guide the client's attention from the external world to the presenting problem.

*Restorative Summarization.* If the counselor begins to feel that they are "losing the client in the details," then it may be necessary to use restorative summation. Restorative summarizing is a key term that represents the broad umbrella of summaries that restore productivity or organization in the client's thought processes with the intent of clarification. For example, the client may say "I asked my wife yesterday, 'can I talk to you for a second?' She said, 'sure,' and I said, 'good, let's talk. Is everything okay? You don't seem like yourself today.' She said, 'well, I'm just not sure I liked how you talked to me the other day.' So I said 'fine, I guess I won't say anything at all to you from now on,' but I felt bad. I shouldn't have said that."

Hearing the client describe this conflict at this level of detail may make it easy to lose sight of the client's main idea. A restorative summarization would be, "it sounds like you initiated a conversation with your wife because you could sense something was wrong. Then you discovered she had been upset with you about something you said to her. You reacted with anger and you regret it. Is that right? Did I get all of that?" The counselor has summarized the main ideas with the client for clarification.

*Distillative summarization.* Distillative summarizing goes beyond restorative and is used to reflect the essence of the narrative back to the client to help her or him see which

parts may be most significant. A distillative summarizing response to the client's story above would be, "it sounds like you could sense your wife was upset, and you regret reacting to her the way you did." The counselor is making the client aware of the important details of the story, rather than maintaining the story's focus. Distillative summarization is also used when clients dwell too much on micro-level details. Other times, it is simply a tool to attain clarity.

*Addressing a limited number of concerns at a time.* As noted earlier, addressing many concerns simultaneously is a client pitfall that counselors should help clients avoid. Active engagement with multiple issues is a symptom of chaotic thinking. Therefore, the counselor encourages clients to stay with one train of thought. Once the thought is resolved, then the other matters can be revisited. The PFC mantra "Don't worry; we will get there." comes to mind.

*Hearkening back to earlier keywords.* The PFC counselor pays special attention to keywords, an emphasis area for productivity focus. Specifically, when a client makes a comment that the counselor views as important, the keywords are retained to be addressed later when the counselor feels it is intuitively appropriate. To test accuracy, the counselor respectfully reports any assumptions about their importance. Some of these assumptions, if correct, transform into interpretations that may provide valuable insight. This technique can also be a valuable tool in redirecting the client to a more productive avenue. When the client veers from what is productive, to avoid a difficult but important topic, the counselor may hearken back to a keyword to rewind to a part of the session when the discussion was productive. Imagine a client who had at one point referred to a text message a former friend sent as venomous, giving no explanation of what the text message said or what was so venomous about it. Then the client tangentially moves on to discuss how their mother thinks they spend too much time on the smartphone. The power of the word venomous, the vagueness of the details about the text message, and the swift transition to a new but loosely related topic together suggests that the client may be avoiding something important about the text message. In this case, the counselor might ask the client to go back to when the word venomous was said and ask for more details.

**Questions inspired by Motivational Interviewing.** As noted earlier, when the client is less talkative, the counselor uses questioning to instigate content generation. The questioning used in PFC in this context is based on the open-ended questions that elicit change-talk as proposed by Sobell and Sobell (2008). For example, a client whose self-defeating thoughts cause the belief that they will never be worthy of a relationship may continue to tell stories within the session to reinforce these negative perceptions. The counselor might ask, "What thoughts might you have if you *believed* you were worthy of a good relationship?"

**REBT-inspired techniques.** REBT techniques are used to address the connection between thoughts, feelings, beliefs, and behaviors (Ellis, 2005). Three of these techniques are integral to the PFC approach: 1) REBT-inspired affirmations, 2) using the four core emotions, and 3) pre-accepting.
*REBT-inspired affirmations*. The PFC counselor can suggest the use of affirmations in which the client rewords the issue in a more rational way. Initially, these affirmations are collaborative efforts with the intention that the client will thereafter construct

their own affirmations. For instance, the counselor may recommend to a client struggling with perfectionism the affirmation, "If I fall short of the expectations I had for myself, I am still competent and worthy of happiness."

*Using the four core emotions*. Based on Ekman's (1992) belief in five core emotions (happiness, sadness, fear/anxiety, anger, and disgust), four are used in PFC as a way to put the client's presenting problem into context. In this intervention, the counselor teaches the client what constitutes happiness, sadness, fear/anxiety. The counselor reaffirms the frequent occurrence of two or more of these core emotions. This helps the counselor discover the client's main emotions associated with the presenting problem. In addition, it assists the client in articulating feelings with an alternative language.

*Pre-accepting*. Another PFC technique inspired by the REBT is pre-accepting. When the client anticipates an unsolvable future challenge or a worst-case scenario, the counselor encourages the client to accept these less preferable circumstances before they occur. With a client who is nervous about giving a presentation at work, the counselor could urge the client to imagine the worst possible way it could go wrong. Once this scenario is visualized, the emotional consequences are processed and the client will realize that even the worst possible result is still manageable.

**The statement of clarity.** A technique unique to PFC is the statement of clarity. Statements of clarity are similar to reflections. They are reflections of the conceptualization of the problem and are descriptions of what the client believes will go unsaid. The client may assume that something will go unsaid for a number of reasons. A perception that the counselor is fearful of the conflict may occur within the client, or the client may feel that the counselor lacks perception. A resistant client may purposely use distraction tactics to change topics when the counselor hits on an uncomfortable issue.

When providing a statement of clarity, the counselor proposes an interpretation of how the component parts fit together in the presenting problem. A statement of clarity is not a solution to the problem, but rather a new unexpected way of thinking about the issue. For example, a client who takes every opportunity to be argumentative is unaware of the inability to get along with coworkers and to socialize with friends. The counselor could use the here-and-now in an antagonistic moment to gently exemplify to the client the current nonproductive communication style. An appropriate approach may go as follows, "The way you're speaking right now invites me to argue with you, and I wonder if speaking that way keeps others at a distance because they don't feel like arguing." The counselor's statement of clarity counteracted the client's assumption that the counselor would avoid confrontation.

**Therapeutic Process**

While PFC is largely an unstructured method, the principles of therapeutic productivity guide the trajectory of the therapeutic process. Within the counselor-client relationship, PFC is neither directive nor non-directive but rather a reactive approach. In PFC, no one is the "expert." The counselor-client relationship in PFC is described as two partners searching for clarity of the unknown. Accordingly, part of the therapeutic process of PFC is an ongoing evaluation and reevaluation of what is productive. The counselor challenges the client to think critically

about constructive ways to approach the presenting problem.

After abstraction of the presenting problem, a statement of clarity is offered with the intent of supporting the client's efforts to view problems in new ways. Once the statement of clarity is offered, the intervention can begin. As PFC is an unstructured approach, the line between conceptualizing the problem and the intervention stage is sometimes blurred. The assumption of PFC is that the enhanced understanding is therapeutic.

Additionally, PFC counselors take a bi-modal approach to problem solving: A problem is either worth solving or not worth solving. Solution-focused techniques are implemented for problems that are worth solving, and REBT is implemented when accepting the problem is more productive. The same core principles are held regardless of the counselor's mode. The counselor acts as a facilitator for helpful approaches to decision-making when in solution mode. In acceptance mode, the counselor uses a combination of accurate empathy and ABCDE thought dissection to facilitate the client in Unconditional Self-Acceptance (Ellis & Ellis, 2006). PFC counselors and Ellis (2005) reject the idea of self-esteem and encourage minimal evaluation of the moralistic self. A PFC counselor would encourage maximum exploratory evaluation of thoughts and feelings to assist the client in identifying irrational beliefs that cause unfavorable emotional consequences.

**Social, Cultural, and Spiritual Issues**

The constructivist framework aspect allows PFC to fit quite naturally with multicultural competency. The counselor views every thought, belief, or assumption about the client as tentative knowledge necessary for intercultural competence. This approach is ineffective when the client is looking for the counselor to be the expert as might be the case for clients of some cultural backgrounds. To address this possible challenge, the counselor may use experiential activities or homework assignments to ensure the client's active participation. Additionally, the gentle directiveness inherent in the focusing techniques may also help give the client a sense of focus.

One fundamental cultural concern is with the REBT component. Johnson, Ridley, and Nielsen (2000) note that religiously sensitive REBT may precipitate ethical issues. Specifically, the counselor may harm the client by discounting spiritual identity. This risk increases when the counselor holds Ellis' (2000, 2004) earlier views on religion too closely. Although Ellis saw devout religiosity as a source of human disturbance for some, he concluded that religion can be instrumental in alleviating human disturbance for those who believe in a beneficent God. This more moderate approach to spirituality will be essential in treating spiritual clients.

**Efficacy**

Future research of therapeutic productivity in the grounded theory tradition could further expand the theoretical framework of therapeutic productivity that drives PFC. In quantitative studies, efficacy could be measured by how much productive content the client produces in a session or in regards to each session.

**Limitations**

Though conducting therapy through the lens of a productivity focus has advantages, the counselor needs to remain flexible in these domains. Inherent in the role of a counselor is the danger of allowing values to guide the session. When a counselor listens

with a productivity-focused ear, aspects of the client's narrative that may be important are sometimes missed. Expert counselors may see this perspective as a reductionist view of active listening, and they may be correct. Particularly for dualistic counselors, this perspective may encourage a rigid direction in counseling sessions. Therefore, the author cautions educators to present this perspective to counseling students as a tentative model that may add to their counseling repertoire, rather than examples of perfectly productive counseling sessions.

## Conclusion

This article has introduced basic principles of Productivity-Focused Counseling including rationale, key concepts and techniques, the therapeutic process, and recommendations for future research. Productivity-Focused Counseling, while in its infancy, may prove to be a valid approach that could be integrated into numerous theories. The emphasis on therapeutic productivity and other PFC principles may be a beneficial addition to therapists from many different backgrounds.

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# Section II: Graduate Students' Articles

## Ethical Decision-Making in Relation to Confidentiality of Client-Assisted Suicide

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Counselors encounter ethical dilemmas throughout the course of their careers. As new issues arise that change legislation, the counseling profession must translate these ethical concerns into new practices. The authors in this paper apply the ethical decision-making model created by Corey, Corey, and Callanan (2010) to an ethical dilemma with regards to confidentiality of a client-assisted suicide. A growing number of states are considering reform legislation to allow end-of-life assistance (Downie, 2016). In this scenario, a client seeking grief counseling discloses to his counselor his intent to assist his terminally ill wife in her suicide request. Utilizing Corey, Corey, and Callanan's (2010) ethical decision-making model, the authors review the applicable ethical codes and laws, offer ethical and unethical potential courses of action, and evaluate the ethical decision made by the counselor in this fictitious case. Ultimately, any ethical dilemma is a step-by-step process and a case-by-case analysis.

*Keywords:* ethical decision-making model, assisted suicide, terminal illness

Counselors are destined to encounter ethical dilemmas that may not fully align with jurisdictional laws or moral principles throughout their careers. Many ethical counseling issues are subjective and do not have concrete solutions. Likewise, there is often room for interpretation in evaluating legal regulations. The complexity of these unique circumstances can leave counselors conflicted between their moral values, ethical codes, and the law.

One such issue is assisted suicide, which has become a subject of increasing attention in recent years (Downie, 2016). Assisted suicide occurs when one person intentionally provides another person with knowledge, resources, or both so that the other individual may take their own life (Darr, 2007). Recent studies indicate that nearly 70% of Americans are in support of assisted suicide in patients with terminal illness (Gallop Organization, 2015; Pew, Research Center, 2013) a significant increase from 46% in 2006 (Pew Research Center, 2006). Although there have been many failures in legislative regime with respect to assisted suicide, some lawmakers strive toward reform which has signified a shift in opinion regarding assisted suicide (Downie, 2016).

At the center of the debate are those who are terminally ill and suffering from immense pain. There remain strong opinions on both sides of the dispute, however as of recent years, support for assisted suicide legalization has greatly increased. Notwithstanding the public attitude towards assisted suicide, the laws in most states remain

unchanged except for California, Oregon, Vermont, Washington, and Montana (Downie, 2016). The success in legislative reform in these states regarding assisted suicide has lead legislation to also be considered in 27 other states (Downie, 2016). However, assisted suicide remains a criminal offense in the state of Louisiana (LSA-R.S. 14:32.12.) thus counselors in Louisiana, may feel conflicted in working with cases that involve assisted suicide.

Counselors faced with ethical dilemmas, including assisted suicide, are expected to utilize an ethical decision-making model as outlined in the *American Counseling Association (ACA) Code of Ethics* (2014). Corey, Corey, and Callanan's (2010) ethical decision-making model provides a step-by-step process through which counselors can identify the ethical issues, ascertain pertinent ethical and legal matters, obtain consultation, develop and analyze all possible solutions, and implement the elected plan of action. The structure of this model is appropriate to evaluate the case of Amber, a licensed professional counselor (LPC) and her client John, who professed his intent to aid in his wife's suicide.

**Case Summary**

John, a 65-year-old Caucasian male received grief counseling from Amber regarding the terminal illness of Luisa, his wife of 39 years. Amber is a LPC who has a private practice in Louisiana. John and Amber completed 19 sessions over the course of seven months. Devout Catholics, John and Luisa have four adult children together. Luisa spent the past year of her life battling thyroid cancer, which is causing her immense pain. John and Luisa were determined to battle the cancer. Unfortunately, treatment was unsuccessful and Luisa's doctors reported that the cancer was terminal and that she had six months to live. Luisa insisted on living the remainder of her life in the comfort of her own home, refusing any medical treatment.

When John entered counseling, it was apparent to Amber that John was grieving the decline of Luisa's health, as evident by his signs of depression. An inability to eat and sleep, indifference in his affect, and deterioration of his physical appearance were present. John began antidepressant medication two months ago, after visiting a psychiatrist, noticing only an improvement in his sleep.

Throughout counseling, John disclosed that Luisa had pleaded with him to consider assisting her in committing suicide. Bedridden, she was unable to acquire the necessary illegal medication on her own. Amber notified John on three separate occasions of the legal implications in regards to breaching client confidentiality, as stated in the Louisiana Professional and Occupational Standards, Title 46, Part LX., §2105.A.1.d., should he inform her that he will assist in Luisa's suicide. She would be required to breach client confidentiality by reporting his intention to the authorities. John and Amber have thoroughly discussed her legal responsibilities as a counselor concerning the disclosure of information surrounding assisted suicide.

Despite Amber's fourth attempt to remind John of her obligations as a counselor to adhere to confidentiality mandates, he confessed his plan to fulfill Luisa's dying wishes. Amber advised him to cease his disclosure, but he continued to disregard her efforts as he felt he needed to talk to someone irrespective of the repercussions. Luisa also requested that John conceal the plan from their children because she knew they would disagree with her

choice due to their religious values. Finally, John shared with Amber that he had obtained the lethal drugs and that he and his wife were preparing for her suicide.

Amber maintained that she appropriately informed John of her legal and ethical responsibilities on several occasions, yet she is torn because of her personal moral values. Amber understands that Luisa is in excruciating pain and recognizes that few alternatives exist. She perceives John to be far from harmful or dangerous and knows that John is only succumbing to Luisa's insistence.

## Application of the Ethical Decision-Making Model

### Step 1: Identify the Problem

An essential element of identifying the problem in John's case is to determine if the problem is ethical, legal, professional, moral, or a combination. Frame and Williams (2005) emphasized the importance of sequestering the crux of the dilemma along with all who are impacted, determining the potential risks, and understanding how various facets of the dilemma affect the client. Additionally, it is important to consider counselors' personal values and insights.

The problem Amber encountered is the disclosure of John's intent to aid his wife in suicide and the appropriate action to take with this information. John, Luisa, and their children are those impacted by the situation. Amber believed John's professions about Luisa's condition and her wishes, which induced a conflict between her personal values and ethical and legal concerns. She empathized with both John and Luisa, however, the prospective risks may have a greater impact on all of those whom it may concern.

### Step 2: Identify Any Issues Involved

A careful deliberation of all issues surrounding John's plan and its effect on everyone involved constitutes the next step in the decision-making model. John may face criminal charges for assisting in Luisa's death. If John's children discover his participation in Luisa's death, it may sever any relationships he has with them. Civil repercussions could arise if John's offspring become aware of his disclosure to Amber after Luisa's passing, should she not report it to the authorities.

**Applicable ethical principles.** Kitchener (1984) described the moral principles of nonmaleficence, autonomy, fidelity, beneficence, and justice that are of assistance in contemplating the issues of this case.

***Nonomaleficence.*** Nonmaleficence is to do no harm to the client (Kitchener, 1984). If Amber reported John to the authorities, John may encounter issues with the police. This action could further compromise his relationship with Luisa, as well as adversely impact the therapeutic alliance.

***Autonomy.*** Autonomy promotes the client's self-determination and encourages the client to make their own choices (Kitchener, 1984). Amber endorsed autonomy by ensuring that John was aware of the repercussions of his self-disclosure. She gave him opportunities to refrain from disclosing information that would force her to break confidentiality. A report to the authorities would undermine John's autonomy, notwithstanding Amber's attempts to remind him of her obligations as a counselor.

***Fidelity.*** Fidelity refers to remaining loyal to the client, maintaining discretion, and fulfilling realistic client commitments (Kitchener, 1984). In anticipation of any questionable client disclosure, Amber

communicated to John on several occasions her responsibilities as a counselor. She remained open and honest with him about her obligations. Nonetheless, John may feel betrayed by the exposure and may not trust Amber or any other counselor in the future.

***Beneficence.*** Beneficence is the will to do good onto others (Kitchener, 1984). In this case, reporting John's intent to the authorities discredits his confidentiality. This course of action might prevent John from assisting Luisa with her suicide and avoid any legal repercussions. Nevertheless, Luisa would continue to bear tremendous pain.

***Justice.*** Justice encompasses treating all clients fairly, but uniquely (Kitchener, 1984). It may be morally difficult for Amber to justify reporting this case to the authorities, however it is her ethical and legal responsibility.

**Step 3: Review Relevant Ethical Codes**

Upon review of the *ACA Code of Ethics* (2014), it is possible for a solution to the dilemma to evolve. These ethical codes accentuate significant components of the counseling relationship including acting in the client's best interest, remaining open and honest with the client, and preserving client trust and privacy (ACA, 2014). This case required a clear ethical understanding of informed consent through respecting client confidentiality. Applying ethical codes pertaining to client welfare and the counseling relationship are also imperative. Moreover, awareness of codes pertaining to counselor values and end of life situations are unique elements in this dilemma.

Inherent in informed consent is the notification of a counselor's professional duties including exceptions to client confidentiality (ACA, Standards A.2.a, A.2.b, B.1.c, B.1.d, I.1.c, 2014). Due to the client's noncompliance and disclosure of intent to assist in suicide, the counselor must utilize a decision-making model to devise an appropriate plan of action with thorough documentation (ACA, Standard I.1.b, 2014). Prior to implementation, the counselor in this scenario considered recommending a family counseling session with the goal of formulating a potential resolution (ACA, Standard A.1.d, 2014). If the client declines, although the counselor empathizes with the client, his disclosure of aiding his wife in assisted suicide warrants the counselor to set her personal beliefs aside (ACA, Standards A.4.b, B.2.a, B.2.b, 2014). She is thus ethically obligated to break confidentiality and report the predicament to the authorities. In addition, she must forewarn the client and encourage his envelopment in the process, (ACA, Standards B.1.c, B.2.a, B.2.b, B.2.e, I.1.c, 2014).

**Step 4: Know Applicable Laws and Regulations**

It is also the counselor's responsibility to retain accurate, up-to-date knowledge of all possible legal implications. Louisiana Law RS 14:32.12. defined criminal assistance to suicide as "the intentional advising, encouraging, or assisting of another person to commit suicide, or the participation in any physical act which causes, aid, abets, or assists another person in committing or attempting to commit suicide," further supported by Louisiana Law RS 40.1299.58.10, which prohibits euthanasia. Beyond exploring pertinent legal statutes is the importance of seeking professional legal consultation to avoid impending civil or criminal repercussions.

Title 46, Part LX of the Louisiana Professional and Occupational Standards: Licensed Professional Counselors Board of Examiners (2015)

provides specific regulations for counselors. Regulation §2105.A.1.d. stated, "counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breached." Additionally, regulation §2105.A.2.d. states, "clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed." These statutes support the breach of confidentiality and the report of the predicament, yet uphold disclosure of only essential information.

**Step 5: Obtain Consultation**

Four experienced clinicians served as consultants to this case and provided the following recommendations to Amber. The first consultation was with an assistant professor in counseling at a local university. The professor affirmed the necessity to break client confidentiality and to report the incident to the authorities. Although he felt morally conflicted, he deemed it mandatory to report. A recommendation for reiterating the policies concerning confidentiality and a suggestion to discuss the situation with the client in-depth and allow 24 hours to self-report were given. The professor ultimately concluded that it is the counselor's responsibility to ensure a report to the authorities, whether done by the client or the counselor.

A counselor with a private practice recommended warning the client of any grounds which entail the counselor breaking client confidentiality, and even suggested the client use hypothetical situations if he still felt compelled to disclose reportable material. He was also greatly concerned with beneficence and nonmaleficence on behalf of the client stating "your license is only as good as how you treat people." He primarily based his decision on what he felt, as a person, was the right thing to do and ultimately "what makes you sleep at night." In such incident, when the client has disclosed reportable information such as in John's situation, this clinician concluded that he would not report and thus be willing to deal with any potential outcomes including civil suits and consequences from the ACA. Ultimately, his decision was to maintain client confidentiality and continue seeing the client.

A third consultation was held with another counselor in private practice who made it clear from the beginning that this is a case in which reporting to the authorities is imperative. He did however recommend seeking guidance from the LPC Board as a supplementary source of advisement. Although his moral beliefs contradicted what he felt to be the necessary courses of action, he believed that legally the counselor could be held accountable as an accessory to murder. He further discussed sequences of civil action the counselor may face from the family. He concluded with emphasizing the importance of thoroughly documenting each step the counselor takes regarding the case.

A final consultation was held with a licensed social worker at a hospital facility who stressed the need to reiterate informed consent to the client and forewarn him that the case mandates reporting. She also mentioned advising him of his options. Due to her previous extensive work experience in hospice, the social worker suggested an informational visit to view a hospice facility and to consult with a physician who could offer John's wife alternative medication options to retain her lucidity and to decrease her pain. She felt as though this would potentially provide the client with a

more favorable impression of hospice. If the client should decide to move forward with assisting suicide, then the social worker advised to have the client write a safety plan for the next 24 hours, including reaching out to a hospice and promising not to assist his wife with her suicide in the meantime. Should the client comply with the safety plan and provide evidence of doing so, she could hold off reporting until having further discussion with the client regarding his decision. If the client chooses not to move forward with the safety plan, she would find it necessary to report.

**Step 6: Consider All Possible and Probable Courses of Action**

Upon gathering and reviewing all relevant information, the counselor devised various possible alternatives. One potential plan of action entailed Amber not reporting John's disclosure and continuing counseling, discussing the dilemma throughout their sessions. This is clearly an unethical decision as Amber would not maintain her professional responsibility to report and to continue counseling. In addition to any legal repercussions she may face, she would risk her career by not complying with ethical and legal codes.

Another plan of action involved the counselor notifying the family and police directly without informing the client first. Through this course of action, the counselor would act in an unethical manner not only by crossing client boundaries, but also by disregarding the client's privacy in discussing the case with the client's family. Amber would also be acting unethically by intentionally failing to inform the client of her plan to report the case to the authorities.

A third potential proposal Amber considered is informing John that she must report his intent to aid Luisa with assisted suicide to the authorities. Amber could utilize this opportunity to discuss with John why he chose to disclose this information to her despite her multiple warnings. This action would require Amber to break client confidentiality. While this an undesirable course, it is still her responsibility to report and it is ethically sound. The desired outcome of this scenario is that police involvement would encourage Luisa to consider other options upon learning about the consequences John could face in assisted suicide. In this scenario, Luisa considers alternative medical treatment that allows her to remain lucid. Moreover, John continues counseling with Amber due to her transparency with him and ultimately avoids any of the legal repercussions which could have resulted from assisting Luisa with her suicide.

A final potential plan required Amber to promote self-determination, enabling John to self-report his plan to aid in Luisa's passing to the police. This can occur by informing John that the she will ultimately need to notify the police and encouraging him to do so on his own. Amber would not breach confidentiality and at the same time promote John's autonomy with this ethically sound decision. The desired outcome of this scenario is that John's self-report would persuade Luisa to consider other courses of action aware of the potential legal repercussions. Likewise, John and Luisa can have an open conversation regarding the situation in which John can encourage Luisa to attend counseling with him. In this plan of action, Amber will need to ensure that John does report the situation to the authorities.

**Step 7: Enumerate the Consequences of Various Decisions**

In this step, the counselor reviewed all possible consequences of

each course of action, and the counselor considered her client's contribution.

In the first plan of action, in which Amber continues counseling with John without reporting the case yields only negative consequences for both John and Amber. Although the desired outcome of this plan is that John's disclosure would remain concealed, there is always a possibility of exposure. This scenario is an unethical course of action, as both Amber and John are at risk of incurring legal charges. Upon the potential revelation of John's participation in Luisa's suicide, he might face criminal charges for murder. Amber could also face criminal charges for being an accessory to murder along with any potential civil proceedings the family may take against her. She would likewise be putting herself at risk in facing disciplinary action from her professional organizations and licensing board. Finally, the revelation of this plan could create turmoil for John's family and they may choose to sever ties with him as a result.

The consequences regarding the second plan of action in which Amber directly notifies John's family and the authorities, would also likely yield conflict between John and his entire family as well. John may also face legal repercussions as a result of planning on assisting Luisa with her suicide being viewed as criminal assistance to suicide. This is also sure to terminate the counseling relationship between Amber and John and potentially prevent John from seeking counseling out in the future. Professionally, Amber would be jeopardizing her career in not properly following protocol. John would also have the means to file a civil suit against her for unethically breaching his confidentiality in reporting the case to his family.

In the third plan of action, Amber discusses with John her intention on reporting the case to the authorities. Potential consequences of this action taken by Amber could cause John to become disgruntled with her and terminate the counseling relationship. This plan may also result in tension between John and Luisa as a result of the reported disclosure he made in counseling. Furthermore, John may face legal issues as a result of his criminal intent on assisting Luisa with her suicide.

In the fourth plan of action, Amber encourages John to self-report to the authorities. The potential consequences of this plan of action could also create conflict between John and Luisa. John may also discontinue counseling as a result of feeling backed into a corner by Amber to self-report. Furthermore, he may agree to report with no intention of doing so. Consequently, if Amber does not ensure that John does report the case to the authorities, she would be liable in ensuring it gets reported to avoid any further legal ramifications.

**Step 8: Choose what appears to be the best plan of action**

In reviewing the available options, Amber selected the last choice, as it appeared to be the best ethical course of action. Amber exercised fidelity by remaining completely open with John regarding supplemental steps she would need to take should John not report. Autonomy was also promoted as Amber enabled John the liberty of becoming proactive in the process through self-reporting. Likewise, beneficence was endorsed through maintaining client confidentiality. John self-report to prevent him from following through with anything that could have potential legal repercussions fostered nonmaleficence. Although Amber demonstrates justice by treating

John fairly, the circumstances are rather unique, and the plan of action could be considered too universal for such exceptional circumstances.

**Applying the four self-tests.** The four self-tests provide counselors with questions regarding justice, moral traces, publicity, and universality to aid in examining decisions made in challenging cases concerning ethical dilemmas (Herlihy & Remley, 2005 & Stadler, 1986).

If there were exceptions to justifiable means to report, it would be this particular instance. While legally John assisting Luisa is considered criminal assistance to suicide, Amber knew John's only intention was to aid his wife in carrying out her dying wish. Though Amber faced moral challenges, she handled this instance in the same manner as in less dire conditions fulfilling justice (Stadler, 1986).

Moreover, counseling ethics and the law challenged Amber morally since she personally supports giving terminally ill patients the right to die. Amber's choice to disclose is not a reflection of personal values. Considering the ethical and legal standards, the chosen approach appears to be the best plan in addressing moral traces (Herlihy & Remley, 2005). Furthermore, the counselor would recommend the same action plan to other counselors with similar case scenarios reinforcing universality (Stadler, 1986).

Although the challenges of this case require a compromise of moral values, the counselor believes that the actions examined adhere to ethical and legal guidelines and consider the impact it could have on each individual involved. Thus, the counselor stands behind this decision and is comfortable with any subsequent public disclosure (Stadler, 1986).

**Implementation and follow-up.** Amber and John will first discuss a proposed plan of action in self-reporting to the authorities. John would call the authorities to report his case in the presence of Amber, assuring that he does self-report and enabling Amber to support him in the process. Furthermore, this facilitates an open line of communication between counselor and client, empowering John to address any questions or concerns in the future. Amber can also offer to hold a counseling session with John and his family to address the issue. Due to her support and John's confessions, contrary to her previous warnings, it is more likely that he will continue counseling. If he continues counseling, he is sure to be careful about what he shares with Amber in future sessions.

## Conclusion

Upon reviewing the presented case, the counselor encountered a client with intent to participate in assisted suicide despite her many warning exceptions to confidentiality. Although Amber morally empathized with John and Luisa's case, assisted suicide is considered homicide in the state of Louisiana. Applying Corey, Corey, and Callanan's (2010) ethical decision-making model enabled Amber to evaluate this case from an ethical, legal, and moral standpoint. Use of model acknowledged the promotion of client autonomy to self-report as the optimal alternative. Moreover, assessing several plans of action in addition to weighing the consequences further supported this choice to be in the best interest of all parties involved.

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*CEU questions for the Productivity-Focused Counseling article:*

1. A principle specific to Productivity-Focused counseling is
   A) A focus on the macro-level
   B) Productive content is the cornerstone of therapy
   C) It is the client's responsibility to know what content is productive
   D) Change always takes place in the therapeutic relationship

2. Examples of unproductive content in PFC include
   A) Preaccepting
   B) Complaining
   C) Ruminating
   D) B and C

*CEU questions for the Multicultural Triadic Network Model in Supervision-of-Supervision article:*

3. What is an important issue that has been traditionally neglected in supervisor training literature?
   A) Developing professional identity
   B) The amount of training hours and mentored supervision hours for novice supervisors
   C) The impact of cultural awareness and competencies
   D) Theories and techniques

4. Appropriate supervisor and 'grand supervisor' interventions under the SOS network and MTN model included:
   A) Exploring viability of self-disclosure
   B) Helping the counselor identify assumptions about the client
   C) Straying from uncomfortable discussions of race or religion
   D) A and B

*CEU questions for the Psychopharmacology Training of Counselors article:*

5. Most counseling program directors support the inclusion of psychopharmacology training, yet
   A) It is unnecessary because counselors rarely encounter medication issues in practice.
   B) 54% of CACREP counseling programs did not offer a psychopharmacology course.
   C) Of departments that do not offer such a course, few reported obstacles to doing so.
   D) The need for training does not exceed available training

6. The most commonly reported potential obstacle to offering psychopharmacology training is:

A) Lack of faculty interest
B) Having to sacrifice another course.
C) Lack of qualified faculty
D)Lack of student interest.

*CEU questions for the It Ain't Your Mama's Yoga article:*

7. When discussing his training to become a Registered Yoga Teacher, what does Stanley say he's come to view yoga as?
   A) An exercise regimen
   B) Technology
   C) A spiritual experience
   D) Mind-body medicine

8. Literature regarding yoga practice has shown that yoga may have significant psychological benefits such as:
   A) Increased self-soothing methods
   B) Improved mood
   C) Reduced anxiety
   D) All of the above

*CEU Questions for the Ethical Decision Making in Relation to Confidentiality of Client-Assisted Suicide article:*

9. Kitchener's moral principles include all the following except
   A) Fidelity
   B) Autonomy
   C) Integrity
   D) Beneficence

10. Which states reformed legislation regarding assisted suicide?
    A) Louisiana, Arkansas, Florida
    B) California, Oregon, Washington
    C) Virginia, Ohio, Illinois
    D) Texas, Colorado, New Hampshire

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

## MANUSCRIPT CATEGORIES

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

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

**MANUSCRIPT REQUIREMENTS**

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

1. Submit an emailed, electronic, blind copy in Word of the entire manuscript to Meredith Nelson, mnelson@lsus.edu, Psychology Dept., One University Place, Shreveport, LA 71115 or three (3) clean, hard copies of the entire manuscript with an electronic version to Peter Emerson, *LJC* Editor, pemerson@selu.edu, SLU Box 10863, Hammond, LA, 70402.
2. Include a cover letter with your manuscript submission that contains your name and title, place of employment and position, address, telephone number, and e-mail address.
3. Manuscripts should not exceed 18 pages, including references.
4. Lengthy quotations (330-500 words) require written permission from the copyright holder for reproduction. Adaptation of tables and figures also requires reproduction approval. It is the author's responsibility to secure this permission and present it to the *LJC* editor at the time of manuscript submission.
5. Once a manuscript has been accepted for publication, the author will be required to submit a final copy electronically.
6. The *LJC* is published annually in the Fall.
7. Material that has been published or is currently under consideration by another periodical should not be submitted.
8. Generally, authors can expect a publication decision within 3 months after the acknowledgment of receipt.
9. Manuscripts that do not conform to the APA *Publication Manual* guidelines will be returned without review.

## Louisiana Counseling Association

# Journal Evaluation

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