

Counseling Today

October 2017 • Volume 60/Number 4

An American Counseling Association Publication

Providing trauma-informed treatment

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- ❖ Narrative therapy and the power of stories
- ❖ The somatic approach in sexual trauma recovery
- ❖ The discussion of desire issues with female clients
- ❖ The role of counselors in addressing recidivism

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Counseling Today

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By Laurie Meyers

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Nonmember regular	\$565	\$595	\$665
Nonmember student	\$405	\$450	\$495



Gerard Lawson

The alphabet of trauma-informed treatment

As I am writing this, American Counseling Association members from across the country are preparing to deploy to Texas and other Gulf states in response to the historic flooding that accompanied Hurricane Harvey. Our thoughts and prayers are with those affected by this storm — a storm that has a historic twist. Following Hurricane Katrina in 2005, about 35,000 individuals who were displaced from Louisiana and Mississippi ended up in Houston. Some of those people remained there and have now experienced another epic storm. This serves as a reminder that many of us carry a trauma history with us that may not be visible to the casual observer. But counselors are not casual observers.

It is my belief that we are all doing trauma work these days. Sometimes those who seek our services have experienced a “capital T” trauma such as a hurricane, flood, school shooting or military combat. These events are almost universally recognized as potentially traumatizing. But every day, counselors are also working with individuals who have endured “lowercase t” traumas. These include the child who has experienced persistent bullying at school, the survivor of intimate partner violence and the person who has sustained a serious injury or illness. We don’t always recognize those experiences as traumatic, but they certainly can be. In an effort to avoid retraumatizing our students and clients, we need to be trauma informed.

When considering trauma, the Substance Abuse and Mental Health Services Administration (SAMHSA) suggests the Three E’s. Trauma is the result of an *Event* (or events) that is *Experienced* as harmful or life-threatening and that has lasting adverse *Effects* on the individual’s functioning across domains.

Research suggests that most of us will experience an event in our lifetime that is potentially traumatizing. Traumatic

experiences shatter our belief that the world is a safe place and can cause us to behave in ways (rational and otherwise) that help us feel safe again. Trauma masquerades as mood disorders or addictive behaviors and may show up in counselors’ offices as difficulty in relationships, at school or at work. Sometimes clients can recognize the connection between their experience of the trauma and their current thoughts, emotions and patterns of behaviors, but not always.

SAMHSA also suggests that trauma-informed care is built around Four R’s. To be trauma informed as counselors, we must *Realize* the widespread experience and impact of trauma. Next, we must *Recognize* the signs and symptoms of trauma, which is sometimes trickier than it seems. Especially in children, trauma responses often appear to be oppositional behaviors when, in fact, they are self-protective behaviors based on previous traumas. So, counselors with this awareness *Respond* by building their practice around policies and procedures that actively integrate the knowledge of trauma and then work to avoid *Retraumatizing* individuals who come to see them.

The hopeful part of this story is that people who have survived a trauma need safety, connections and coping skills, and these are areas where counselors shine. We help our clients find safety by understanding what their emotions and thoughts are trying to tell them and responding in ways that are healthy and constructive. We can help them reestablish connections and build new relationships with natural supports. We can also help our clients fill their toolboxes with strategies for handling the day-to-day challenges that emerge from traumatic events as they work toward establishing a new way of living in the world.

The last, and in some ways most important, consideration for trauma-informed treatment is self-care. We have to recognize the toll that bearing witness to the suffering of others can take and be active in caring for ourselves. Sadly, there will be more traumas, and good client care begins with good counselor self-care. ❖

Counseling Today

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Call for Applications

Editor of *JCD*

The Publications Committee of the American Counseling Association (ACA) is seeking applications for editor of the *Journal of Counseling & Development (JCD)*, ACA's quarterly flagship journal. *JCD* publishes practice, theory, and research articles across 20 different specialty areas and work settings.

The *JCD* editor provides oversight of the peer-review process for approximately 250 article submissions per year, communicates with authors and selects articles for publication in each issue, and recruits and maintains the editorial review board.

Editor Qualifications

- Previous experience as an editor of a peer-reviewed journal
- A significant publishing record that includes publication in peer-refereed journals
- Membership in ACA and a history of involvement in and contribution to ACA through its divisions, organizational affiliates, branches, governing bodies, or committees
- A commitment to ACA's mission and to promoting high-quality scholarship in the journal
- A belief in the importance of advocating for multicultural competence in counseling
- Demonstrated leadership ability and strong decision-making and organizational skills
- Familiarity with ScholarOne or a similar electronic peer-review system
- A solid commitment from the applicant's university/employer for financial and editorial support



The appointment of editor is for a 3-year term beginning July 1, 2019, with the possibility for the editor to be reappointed for a second 3-year term. The successful candidate will begin serving as editor-elect July 1, 2018. The *JCD* editor receives a \$1,000 monthly stipend for editorial services and the journal has an annual budget of \$50,000 for editorial office expenses.

Application Requirements

- A statement from the applicant discussing his or her key qualifications and strategic vision for *JCD*
- A complete list of publications and reprints of three of the applicant's most significant journal articles
- A current curriculum vitae
- A statement from an administrator of the applicant's institution/employer describing support for the appointment

All applications must be received no later than **December 31, 2017**. Late or incomplete applications will not be considered. The Publications Committee will screen all candidates and present its top nominees, in ranked preference, to the ACA Governing Council for approval at the ACA Annual Conference & Expo in Atlanta, April 26–29, 2018.

Send application by **December 31, 2017**, to

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Richard Yep

One year in and the changes we face

Next month will mark the first anniversary of one of the most impactful, discussed and upending national elections in U.S. history. More importantly, that election was the beginning of a whole string of events that brought some groups together, drove a wedge between others and began a roller coaster of emotions connected to some of society's most critical issues, including health care policy, immigration, interpersonal relations, the environment, professional counselors' ethical practice and discrimination. Underlying all of this is a question: What kind of community and society do we want to be?

Let me be clear. This column is not about being a Democrat, a Republican or an independent. Rather, the questions I'm raising are ones that professional counselors need to address as they grapple with how best to help their clients or students and the communities in which counselors work.

During the past year, the American Counseling Association has adopted and disseminated many position statements and policy briefs. Statements have focused on issues such as transgender persons in the military; the riots in Charlottesville, Virginia; support of those impacted by Hurricane Harvey; access to all-sex bathrooms; and nondiscrimination. These statements and positions are not left-wing, nor are they right-wing. Rather, they support the association's belief about providing important information and resources to those who work as professional counselors or counselor educators and to graduate students who are preparing to work as professional counselors.

I think it is important for professional counselors to be keyed in to critical issues happening in society. However, I have started hearing people say, "I just can't turn CNN on or pick up a newspaper anymore." They're saying this because of their fatigue over the latest crisis, issue or tweet that is being reported. Again, this is not a dig at our nation's president so much as it is an observation of how good people, who want to do good things for our society, are being worn down by what they see in the news and on social media.

I encourage all of us to stay abreast of the news but also to think about our role in making a difference, in part by helping to unite and mitigate the divisiveness that continues to grow. Just as society is changing, professional counseling must adapt and align to that change. At ACA, we realize that change is necessary. Your ACA staff is working to make the transformation necessary to help carry out the strategic plan that your Governing Council is crafting. We have invested many hours of dialogue, decision-making and consensus building to develop a strategic plan that will help guide us over the next few years and into the future.

I'm interested in knowing whether the work you do with your clients and students has changed over the past year. Do you find it to be pretty much "business as usual," or have new issues emerged? Are these "new" issues actually the same issues but framed in a different way? Have you felt the need to alter how you work with your clients or students?

We are living in interesting, possibly confusing, but most certainly complex

Continued on page 50

Counseling Today

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Mission Statement

The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession and using the profession and practice of counseling to promote respect for human dignity and diversity.



The American Red Cross and disaster mental health

I read Laurie Meyers' article "Lending a helping hand in disaster's wake" (August 2017), and I was impressed by the breadth of her attention and, of course, the quality of her writing. I was concerned, however, about the absence of any mention of the American Red Cross (ARC) disaster mental health (DMH) component.



The ARC/DMH program has been a significant leader in direct delivery of mental health services to persons, communities and multiagency volunteer responders. I have been a part of that response for over 15 years in the areas of direct response, community psychological first-aid training and volunteer recruitment. Our training to general disaster volunteers, specifically the DMH volunteers, also addresses the spiritual component described in Ms. Meyers' article.

The ARC has advanced that response in the past years with the addition

of a Red Cross chaplain service (nondenominational). I encourage any licensed professional counselors, school counselors, retired counselors and students to seek involvement and training from the American Red Cross, Disaster Mental Health Services Division. You can volunteer locally or nationally. Enrollment is available online at redcross.org/become-a-disaster-mental-health-volunteer. You can also call the local Red Cross chapter listed in your phone book.

*Anne R Harris, LCPC
Disaster Mental Health Liaison
Idaho Montana Region*



Thanks for the salient overview in Laurie Meyers' article with regard to disaster mental health (DMH). The article provided an excellent glimpse into the many facets of DMH work.

As a recipient of DMH training taught by Red Cross personnel and ACA members at an ACA Conference post-9/11, I was moved to volunteer both locally and nationally as a Red Cross mental health disaster responder, and I have worked a wide range of events, from Hurricane Katrina to the Sandy Hook school shootings. It's important to remember that this work starts locally in your communities with local events that have traumatic impact, so give some

consideration to becoming involved locally as well as nationally.

DMH work is challenging, can push your personal limits and will leave indelible impressions with you. It also will leave you feeling the one thing that we all hope we can do as counselors — make a difference in someone's life by bringing comfort when there is none to be found.

*David J. Denino, LPC, NCC
Red Cross State Lead for DMH,
Connecticut/Rhode Island
Director Emeritus, Counseling Services,
Southern Connecticut State University*



I have been a disaster mental health volunteer with the Red Cross since 1999. Needless to say, I have seen and been exposed to the devastation of family homes and the trauma that people have to endure.

I teach psychological first aid, a class we require each new volunteer to take before they can deploy to a disaster. The focus of the class is self-care and to watch out for any signs of distress in volunteer colleagues with whom you will be working. We cannot take care of clients if we are not OK ourselves. Generally, volunteers have never been exposed to the scenes they will encounter during a disaster. Hence, the focus on our own

Letters policy

Counseling Today welcomes letters from ACA members; submissions from nonmembers will be published only on rare occasions. Only one letter per person per topic in each 365-day period will be printed. Letters will be published as space permits and are subject to editing for both length and clarity. Please limit letters to 400 words or less. Submissions can be sent via email or regular mail and must include the individual's full name, mailing address or email address and telephone number.

ACA has the sole right to determine if a letter will be accepted for publication. *Counseling Today* will not publish any letter that contains unprofessional, defamatory, incendiary, libelous or illegal statements or content deemed as intended to offend a person or group of people based on their race, gender, age, ethnicity, religion, sexual orientation, gender identity, disability, language, ideology, social class, occupation, appearance, mental capacity or any other distinction that might be considered by some as a liability. ACA will not print letters that include advertising or represent a copy of a letter to a third party. The editor of *Counseling Today* will have responsibility for determining if any factors are present that warrant not publishing a letter. Email your letters to ct@counseling.org or write to *Counseling Today*, Letters to the Editor, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22304.

volunteers, to ensure that they are coping. The Red Cross is in desperate need of volunteer licensed professional counselors all over the U.S. Deployments are generally for two weeks. There are also opportunities to do virtual mental health in the aftermath of a disaster. This means that you can stay at home behind your computer and talk to clients who have been identified as needing extra support in the aftermath of a disaster.

The Red Cross is neutral regarding clients' religious orientation. We serve everybody. Of course, we recognize and support clients who bring spirituality into the conversation. However, as volunteers, we do not initiate this during intake.

As ACA President Gerard Lawson pointed out in "Lending a helping

hand in disaster's wake," we are there to support clients, to help them feel competent and to be in charge of their own recovery. Every time I return home from a deployment, I am amazed at how resilient the human spirit is, especially when it requires us to survive a major or minor disaster in our lives.

Martha Iskyan, Ph.D., LPC, LSW

Editor's note: ACA is an official American Red Cross disaster mental health partner organization. As part of this partnership, ACA recently assisted the American Red Cross in deploying professional counselors to Houston in the aftermath of Hurricane Harvey. To learn more about becoming a disaster mental

health volunteer, visit redcross.org/become-a-disaster-mental-health-volunteer. ❖

Correction

In the August profile of ACA President Gerard Lawson ("That I may serve"), Nicole R. Hill was incorrectly identified as the president of Chi Sigma Iota (CSI). She is in fact CSI's president-elect. Barbara Herlihy serves as the current president of the international honor society of professional counseling.

Know someone who deserves special recognition for his or her commitment to the counseling profession?

Nominate an Outstanding Counseling Professional for an ACA 2018 National Award!

Each year ACA recognizes and celebrates the achievements of counseling professionals who have distinguished themselves professionally, as well as through service to others.

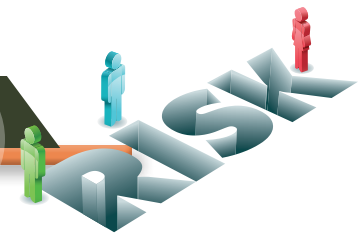
All nominations must be submitted electronically by November 12, 2017.

Some awards require supporting material. For detailed information about each award and the nomination process, please visit counseling.org/nationalawards.

The National Awards will be presented at a gala ceremony during the ACA 2018 Conference & Expo in Atlanta, Georgia. Award recipients and their nominators will receive invitations to attend the awards reception at the Conference.



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Protected health information and the HIPAA breach portal

Question: I recently had to report a HIPAA/HITECH breach of protected health information to the U.S.

Department of Health and Human Services Office for Civil Rights (HHS OCR) because my laptop was stolen. This was a difficult and expensive lesson. I am concerned about the effect of this public report on my reputation and am also concerned that a few of my clients with anxiety or obsessive-compulsive disorder may ruminate about this breach because it is posted online. I heard from a colleague that the government was considering limiting the amount of time such a report appears on the HHS OCR website. Is this true? When will this information about the breach be removed from the website?

Answer: The federal government recently made substantial changes to its Health Insurance Portability and Accountability Act (HIPAA) breach portal (commonly referred to in Washington, D.C., as the HIPAA “Wall of Shame”). See ocrportal.hhs.gov/ocr/breach/breach_report.jsf. To address your question, I’ll provide a brief history of this tool and an explanation of the government’s action.

Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009. That law requires HHS OCR to maintain a public list of breaches of protected health information involving

500 or more individuals; thus, the breach reporting tool was created. The law does not specify how long the information must be retained on the portal, however. A number of people raised concerns, similar to yours, that the portal was overly punitive to providers who may have been the victims of circumstances over which they did not have full control, such as theft or hacking.

On July 25, HHS OCR issued a press release that unveiled changes to the online breach reporting tool (see hhs.gov/about/news/2017/07/25/hhs-unveils-improved-web-tool-highlight-recent-breaches-health-information.html). The portal now displays the most recent breaches first. Breaches reported more than two years prior to the current date are now archived, along with closed investigations. Additionally, HHS OCR will provide a full list of breaches going back to 2009 for research purposes.

According to the press release, the changes to the breach reporting tool should enhance functionality, improve navigation, archive the older material and provide tips for consumers. The main purposes of the revised tool are to help individuals identify breaches and educate the industry to improve security.

Back to your question: Although the focus of the new tool is on *recent* breaches and steps taken to resolve those breaches, your information will be archived after two years. In short, although your information will not remain visible on

the main page, neither will it disappear from the site completely, at least for the foreseeable future.

Something else important for counselors to be mindful of is that even breaches affecting fewer than 500 individuals or clients require year-end reports to HHS OCR. These smaller breaches are not included on the online portal, however. More information is available at hhs.gov/hipaa/for-professionals/breach-notification.



The question addressed in this column was developed from a de-identified composite of calls made to the Risk Management Helpline sponsored by the American Counseling Association. This information is presented solely for educational purposes. For specific legal advice, please consult your own local attorney. ♦

Anne Marie “Nancy” Wheeler, an attorney licensed in Maryland and Washington, D.C., is the risk management consultant for the American Counseling Association’s Ethics Department.

Letters to the editor:
ct@counseling.org



Start on time, end on time

Whether you're 6 or 60, there's one thing everyone hates when going to the doctor. No, it's not getting pricked with needles. It's *waiting* to get pricked with needles. Your appointment is at 2, but as 2, 2:05, 2:10 roll by, you ruminates: "I had an appointment. If the doctor wasn't going to be available, why schedule at this time? Apparently, *my* time isn't valuable."

Our lives are perhaps more rushed than ever, meaning that waiting for any appointment or meeting is a hassle. However, a tardy counseling session is qualitatively worse than other late meetings. Getting started late for a counseling session is a broken promise in a relationship that needs trust in spades.

We've polled our clients. Sessions starting late is their No. 1 complaint. Think about that. It's not clinical care, it's not parking, it's not price. It's timeliness. Thankfully, we don't allow this problem to happen often.

Start on time

When possible, start the day early. Arrive at least 20 minutes before your first session is scheduled to begin. When your first client arrives, begin the session. You might gain two minutes, or you might gain 10. Explain what you're doing and why: "John, would you like to get started early? Great, this will help me stay on schedule today. OK, we're starting at X, which means we'll end our session at Y."

After that first session ends, look for other times throughout the day when you can pick up minutes. If the next client arrives early, see that client early too. Repeat this whenever you can, including after lunch or if you have a gap between sessions.

After a session ends, resist the temptation to sit in your office until the top of the hour. I know that temptation! At Thriveworks, our clinicians, in their desire to provide better service, decided

to hold themselves accountable by posting a sign in the waiting room for all to see that says, "97%+ sessions begin on time or early." They did this because they know (as we all do) that we have the best of intentions — until we get tired. Then the desire to zone out for a few minutes overpowers our commitment to see our clients on time. (Note: I'm not saying to become a machine. If you really need more time to rest between sessions, book fewer clients or schedule breaks between your sessions. That's OK!)

That brings us to the next thing. You'll never be able to start on time if you don't end on time ...

End on time

Ending on time is difficult. I have witnessed new counselors run over when they feel like they haven't "done enough" in session. Even seasoned counselors can run late with talkative clients because it's a challenge to cut them off. The difficult truth is that when a client leaves a session, things are often left unresolved. If you had another hour, you'd be able to make more progress.

However, if you don't end on time, you won't have time to write your notes after the session, and that is the very best time to do them. Immediately after ending, the session is clear — clearer than it will ever be. And as tired as you might feel after a session, it's nothing compared with how tired you'll feel at the end of the day, which is when many counselors try to do their notes. In my experience, at the end of the day, notes that should take me 30 minutes to finish instead take hours.

Let clients know that if they arrive late, you will still need to end on time. This rule isn't fun or easy to enforce, which is why the first time a client should hear about this is during a thorough informed consent process.

Finally, ending on time is imperative if you want to keep the doors open. We'd

all like to have more time in session, but if a client's insurance pays for 45 minutes, giving an hour (just 15 more minutes) means that 25 percent of your time goes unpaid. Reimbursement rates simply aren't designed to allow for such an overage. This is a difficult truth.

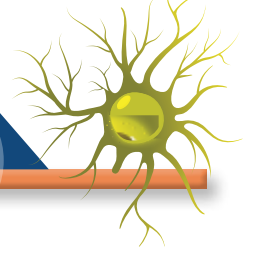
The silver lining is that although you can provide only one service per day, you can provide that service every day. This means that clients who need more time can opt for more than one session per week — and that *is* covered by insurance.

A difficult discipline

Running sessions that start on time (or early) and end on time is good for you and good for your clients. An interesting factoid: Although we've received complaints about sessions starting late, we've never once received a complaint about sessions ending on time. What do you think about starting and ending on time? Let me know: [@thriveworks](https://twitter.com/thriveworks) or [@anthonycentore](https://twitter.com/anthonycentore). ❖

Anthony Centore is a licensed counselor and founder of Thriveworks, a chain of 50-plus counseling centers. He serves as the American Counseling Association's private practice consultant and is author of the book *How to Thrive in Counseling Private Practice*. Find him on Twitter [@anthonycentore](https://twitter.com/anthonycentore) or by emailing anthony@thriveworks.com.

Letters to the editor:
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Marijuana: Neurological friend or foe?

The increased recreational use of marijuana has reignited a long-standing debate on its relative health benefits and dangers. As of the writing of this article, 29 states and the District of Columbia have legalized or decriminalized the use of marijuana for recreational or medical purposes. Many professional health care associations applaud the trend to decriminalize marijuana use, but they continue to warn about the risks of dependency, addiction and long-term neurological impairment associated with adolescent use. Regardless, with today's state government approval, growing positive media coverage and increasing medical application, the idea that marijuana must be safe and harmless seems to have permeated the cultural psyche.

What is the truth about marijuana and its neurological consequences? Is it friend or foe? How might clinicians work with clients who present with recreational or medical marijuana use? The purpose of this article is to explore these questions and to offer some neurologically based direction for those struggling with the consequences of today's marijuana renaissance.

Brief history of marijuana

Marijuana, or cannabis, and the growing of hemp (the plant fiber) for paper, cloth and rope have been around for centuries. Use of hemp as a fabric has been traced to 8000-7000 B.C. Uses for medical purposes were recorded as early as 2700 B.C. by Shen Nung, one of

the fathers of Chinese medicine. Many cultures viewed hemp as a gift from a divine spirit. It was used in ceremonial garb, as incense, for meditation, for enhanced awareness and for pleasure.

Early American colonists were urged to cultivate hemp for paper and cloth as an American trade product. In 1914, to stem the growing use and addictive consequences of cocaine in common health remedies, the U.S. government defined drug use as a crime. In 1937, marijuana was taxed and its nonmedical use outlawed on the national level. In the 1950s, mandatory sentencing was imposed for drug offenses, but by the 1970s, enforcement of these laws was eased. Then in 1996, California became the first state to legalize the use of medical marijuana. Since that time, the trend toward decriminalization and medical and recreational use of marijuana has continued.

Active ingredients and use

The primary active ingredients in marijuana are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD). THC binds to the brain's cannabinoid receptors and is responsible for the subsequent psychoactive euphoria or high. For some people, this can lead to problems with dependency and addiction. These receptors are part of the endocannabinoid system in the brain, and they influence appetite, pain sensation, mood and memory. They can also alter motor control, coordination and judgment,

which can in turn contribute to unintentional death or injury, such as in motor vehicle accidents.

CBD, the most common cannabinoid, does not bind to these receptors and lacks noticeable psychoactive effects. The most frequent pharmaceutical applications for CBD include use in anti-inflammatory, anti-anxiety, anti-epileptic, sedative and antipsychotic agents. CBD also has neuroprotective properties for some cancers, diabetes, rheumatoid arthritis, brain or nerve damage caused by stroke, alcoholism and Huntington's disease.

The primary problem with today's marijuana promotion and use is that the consumer typically assumes that over-the-counter whole marijuana possesses all of the beneficial qualities and none of the risks associated with psychoactive THC. Furthermore, the purity, dose and formulation are not controlled, so the expected positive and negative effects of its use are truly unknown. In addition, although the direct sale of marijuana to minors is prohibited, marijuana use among teenagers is increasing.

The research on long-term, heavy marijuana use is very concerning. It has been associated with an array of psychological, emotional, cognitive and physical problems, including decreased educational achievement, decreased appetite and quality of diet, poorer lung health, sleep difficulty, strange and unusual dreaming, restlessness, nervousness, increased irritability, decreased satisfaction with self and life, decreased happiness and decreased income.

The Food and Drug Administration currently approves THC for medical use in a nonsmoked form for HIV, cancer, chronic pain and multiple sclerosis. It has been found to reduce the nausea, anorexia, stomach upset and anxiety experienced by HIV patients. THC also counteracts the side effects of chemotherapy by decreasing nausea and increasing appetite in cancer patients. In addition, THC has been used to reduce (by as much as 30 percent) otherwise difficult-to-treat neuropathic pain from a variety of causes, including injury, HIV drugs and diabetes. THC has also been found to significantly reduce muscle spasticity associated with multiple sclerosis. Clearly, marijuana has several beneficial effects for those struggling with these debilitating medical conditions.

Caution for teenage consumption

On the other hand, some factors associated with marijuana use warrant both legal prohibition and medical warning. Starting marijuana use before age 17 has been found to decrease overall brain volume and cortical gray matter and increase cerebral blood flow and white matter volume. In addition, both males and females who started marijuana use before age 17 were physically smaller in body height and weight. Males were especially affected, showing delay in the development of secondary sexual characteristics. Early cannabis use has also been linked to lasting consequences on cognition, episodic memory and IQ, with a loss of up to eight IQ points not recovered in adulthood.

Furthermore, heterosexual men between the ages of 18 and 28 who engage in chronic intensive use have decreased testosterone levels and experience significant changes in normal male reproductive physiology. More specifically, research on the effects of THC (for both males and females) on the neuroendocrine regulation of hormone secretion has found inhibition in the production of gonadotropin, prolactin, growth hormone and thyroid-stimulating hormone, and an increase in the release of corticotropin. These effects negatively impact the functioning of the reproductive system, lactation, metabolism and the endocrine stress axis.

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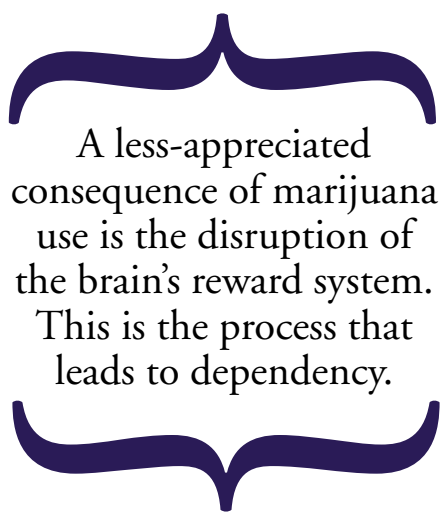
Puberty presents a highly vulnerable period for both neurological and physiological maturation. Marijuana use has been found to disrupt this vital process, derailing the essential reorganization of neuronal structures. Without normal developmentally driven neuronal pruning and consolidation, cognitive, emotional, physical and hormonal maturation are inhibited, delayed and, in some aspects, permanently disrupted. These results may increase the risks of future neuropsychiatric disorders, illegal drug use and marijuana dependence.

Potential positive benefits

Research on the possible benefits of marijuana is continually expanding. Researchers have found that marijuana decreases the effects of eye pressure caused by glaucoma, slows its progression and thereby aids in the prevention of blindness. Continual use has been found to expand lung capacity, perhaps because of repeated deep inhalation of smoked marijuana. Marijuana's ability to bind to the brain cells related to excitability and relaxation have resulted in decreases of epileptic seizures. In low doses, it has been found to decrease anxiety and increase mood and associational and creative thought. However, in high doses, marijuana increases anxiety and feelings of paranoia and can trigger psychotic states. Marijuana has also been found to "turn off" a gene implicated in the spread of cancer and is commonly known to decrease pain and nausea and increase the appetite in those undergoing chemotherapy.

In addition, marijuana has been found to help manage the effects of Crohn's disease, an inflammatory bowel disorder, by causing the cells of the intestine wall to bond tighter together, thus decreasing the permeability of the intestines and blocking bacterial entry. Marijuana also counteracts the side effects of hepatitis C by decreasing fatigue, nausea, muscle ache, appetite loss and depression. Cannabis has also been used to decrease pain and disrupted sleep associated with the discomfort of arthritis.

Researchers studying lupus have found that marijuana calms the immune system and decreases the pain and nausea that frequently accompany the autoimmune



A less-appreciated consequence of marijuana use is the disruption of the brain's reward system. This is the process that leads to dependency.

disorder. Research on posttraumatic stress disorder (PTSD) showed that marijuana has a calming effect on the body and the brain, helping to regulate the fear and anxiety generated by limbic area overactivation. In addition, marijuana has been found to eliminate the nightmares associated with PTSD by disrupting the deeper stages of the sleep cycle. This, however, may have longer-term negative consequences because of the lost benefits of deep recovery sleep.

Still other researchers have noted marijuana's relatively reduced adverse impact as a "harm reduction strategy," citing the potential decrease in the physiological effects of long-term alcohol abuse. Although acute intake of marijuana has been found to stimulate the hypothalamus and cause an increased sense of enjoyment and appetite, regular use has been associated with weight loss due to increased metabolism.

Finally, the neuroprotective potential of marijuana has been studied in THC's ability to inhibit the formation of amyloid plaques and slow the progression of Alzheimer's disease. THC has also been shown to bind to the nerve receptors and decrease the spasms and pain associated with multiple sclerosis. Furthermore, it has been found to smooth the tremors, reduce the pain and improve the fine motor skills of those with Parkinson's disease. Perhaps even more intriguing, research has demonstrated that marijuana can reduce the size of the area affected by a stroke and reduce bruising and facilitate neuronal healing after a concussion or traumatic brain injury.

Potential negative consequences

Common acute negative consequences of marijuana use include an initially increased heart rate of 20 to 50 beats per minute that eventually calms down, red eyes due to the expansion of ocular blood vessels, dry mouth due to decreased saliva production and the "munchies" due to stimulation of the hypothalamus. Other acute consequences include problems with judgment, balance, posture and coordination due to the effects of cannabis on the frontal cortex, cerebellum and basal ganglia. This is what makes the operation of a motorized vehicle under the influence of marijuana a very dangerous endeavor.

A lesser-known negative consequence is blocked memory formation due to marijuana's impact on the hippocampus. In teenagers, this can lead to long-term cognitive deficits. In adults, it can lead to quickening of age-related brain cell loss.

Still another less-appreciated consequence of marijuana use is the disruption of the brain's reward system. This is the process that leads to dependency. The initial surge of dopamine and its resulting euphoria eventually wane as the brain becomes overstimulated. With chronic use, interest in the enjoyment and stimulation from normal activities is decreased and amotivational syndrome dominates, creating lethargy and further decreasing the brain's ability to enjoy normal sources of satisfaction and motivation.

As previously mentioned, sleep quality is also affected, with the brain losing its ability to reach deeper levels of REM sleep. This impacts nightly physiological and neurological recovery via glial cells that rid the brain of unwanted toxins and damaged neuronal material. It also inhibits memory consolidation and disrupts the psychoemotional healing provided by deep-sleep dream states.

Other psychoemotional consequences of ongoing marijuana use include increased depression for those with a genetic predisposition to depression; increased anxiety, distrust, panic and paranoia for about 20 to 30 percent of ongoing users; and increased risk of schizoaffective disorder and psychosis that includes delusions, hallucinations, loss of identity and a phenomenon called "looping sounds" that involves repeated auditory echoing.

Neurological effects

Daniel Amen, a psychiatrist and neurologist who has collected a library of SPECT (single-photon emission computed tomography) scan images of the brain functioning of long-term marijuana users, has concluded that “marijuana is toxic to the brain.” He asserts that it decreases overall brain activity and cerebral blood flow and causes problems with attention, focus, planning, impulse control and motivation. He has also noted slowed neurological activity in the frontal-temporal areas of the brain that affect executive function, memory, learning and mood stability. The functions of the prefrontal cortex involve focus, planning, impulse control, making good or bad decisions, attention span, organization and follow-through. The functions of the temporal lobes include memory, learning, motivation (or amotivational syndrome), and involvement and engagement (or apathy, lethargy, social withdrawal and loss of interest in activity).

Amen emphasizes that marijuana is not selective in its impact on the brain. Although it does calm areas that are overreactive, such as in problems with anxiety and trauma, it does this by calming the entire brain, including essential areas that are necessary for healthy functioning. He has concluded that marijuana is addictive and rewires the brain’s pleasure centers, intensifying a craving for the drug. When ceasing use, intense irritability emerges as the temporal lobes begin to regain normal function. In two to three months, SPECT scan improvements can be observed in brain areas responsible for motivation, concentration and focus.

As previously noted, brain tissue changes have also been identified in ongoing marijuana use. The density of gray brain matter is related to the function of the neuronal cell bodies within that particular area. The density of white brain matter is related to the connectedness or communication of neurons with one another in that area or tracts of neurons across areas. The changes observed related to marijuana use include:

- ❖ Lower gray matter density in the right parahippocampal gyrus (affecting memory)

- ❖ High gray matter density in the precentral gyrus (affecting voluntary movement) and right thalamus (affecting sensory perception)
- ❖ Low white matter density in the left parietal lobe (affecting sensory processing)
- ❖ High white matter density in the parahippocampal (affecting memory) and fusiform gyri (affecting recognition of faces and expert objects) and left precentral gyrus (affecting movement)

Finally, the effect of marijuana on the brain’s electrical activity also confirms its impact on the frontal lobes, thereby disrupting executive functioning, memory, emotional awareness and emotional regulation. The primary impact is the creation of what is called “alpha hyperfrontality.”

The alpha brain wave is generally understood as involving a state of “calm focus” and is defined as occurring within a range of 8 to 12 hertz (cycles per second) of electrical activity. The lower end of this range is associated with cognitive inefficiency, whereas the higher end is associated with cognitive efficiency; the middle (10 hertz) serves as the point of optimal balance and functioning. With ongoing marijuana use, the optimal alpha wave slides to the lower end and dominates the frontal cortex. This creates a state of neurological function akin to attention-deficit disorder and early onset dementia. This not only impairs the functions associated with the frontal cortex but also affects the many neurological networks that interact with it, such as motivation, emotional response, physiological activation and cognitive functioning.

A second effect of marijuana use on the brain’s electrical activity involves a decrease in the gamma waves (40 hertz). Gamma waves are involved in the experience of insight, satisfaction and happiness, which aid in the consolidation of learning. Of course, the duration (age of commencement and years of continued use), dose and frequency of marijuana use combine to determine the severity of its consequences.

Finally, it is important to note that the neurological consequences of marijuana use, dependency and addiction can be significantly reversed with a combination of traditional substance abuse treatment

and neurofeedback. Outcome studies have found a reduction in relapse rates from 80 percent for 12-step programs alone to 20 percent for combined approaches.

Clinical implications

1) Comprehensive assessment of marijuana use is essential in the diagnosis, treatment plan formulation and treatment of all presenting problems.

2) Adolescents and young adults up to age 28 should be strongly discouraged and, where possible, prohibited from any marijuana use unless medically recommended.

3) The positive benefits of marijuana use for those struggling with a debilitating medical or mental health condition must be carefully weighed against its negative consequences. Individuals are best advised to first exhaust all other treatments that are less risk inherent.

4) Client education concerning the risks of even recreational marijuana use and its neurological, cognitive, motivational, emotional and developmental consequences should be promoted.

5) The most effective treatment for marijuana dependency and addiction must address its behavioral, physiological, emotional, interpersonal and neurological consequences. Currently, the most comprehensive treatment approach combines a 12-step-oriented program with neurofeedback.

6) Counselors need to continue to advocate for treatment assistance and decriminalization of marijuana offenses. ❖

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To tell or not to tell: The fine line between minors' privacy and others' right to know

Working with children and adolescents can be tremendously rewarding because early intervention can stave off a multitude of major issues down the road. Minors do not always make for the most communicative of clients, however, and sometimes counselors find themselves at a loss for how to move teens past their knee-jerk “I don’t know” responses to get to the real work that needs to be done.

As is the case with all clients, the establishment of trust is crucial when working with minors. One way a counselor can build that trust is by not telling others — especially parents — every last detail of what was said in a counseling session. Trust can take weeks or even months to build, but it can be shattered in a moment — and possibly forever.

Counselors working with children and adolescents in any setting often find it challenging to balance their obligation to keep private the information disclosed in confidence to them with others' right to know. Professional school counselors are no exception, and in addition to having to answer to parents, they also have obligations to others, including teachers, building administrators, school districts, school boards and the community.

Fielding requests for confidential information

Over the course of a single day, school counselors may have to carefully navigate requests for confidential student information from others. Sometimes the pressure can feel overwhelming. What complicates the situation is that the legal right to confidentiality usually resides with parents and guardians, not with students, although counselors have an ethical duty to maintain students' privacy.

Once a relationship of trust has been established with the counselor, students may reveal information that they absolutely do not want getting back to

their families. This information may range from the seemingly benign, such as secretly wanting to be a stand-up comedian rather than taking over the family business, to more serious issues such as drug use, sexual activity or breaking the law.

It is understandable and natural for parents to want to know personal details about their children. Often, the motivation is well-meaning, such as wanting to better protect their children. Chances are great that if the counselor is hearing one-word answers to his or her questions to the student, so are the student's parents, which make them all the more driven to find out what their child really thinks and feels. Indeed, parents could rightfully complain to the principal, or even the school board, should they discover that the school counselor was privy to prior crucial information that might have enabled them to intervene before serious consequences occurred.

In addition, sometimes parents distrust the counseling process and are fearful that family secrets will be uncovered in the counseling session. They may even have instructed their child not to talk about such topics as an impending divorce or an incarcerated parent, perhaps because they fear they will be judged by the counselor or that the counselor will share this information with others. More recently, in light of changes to immigration policies, parents have become particularly guarded around school officials when it comes to discussions about their immigration status or that of their children.

In addition to parental pressure to disclose the content of counseling sessions, principals and others in the school building may request that counselors reveal information shared in confidence that could incriminate a student for breaking school rules or being involved in illegal activity on or outside of school property. Principals may insist that counselors reveal any information they have learned

about underage drinking parties taking place off campus or possible gang activity in the school district. They might insist that counselors report the HIV status of students, making the argument that school safety is at stake.

Counselors may be tempted to breach confidentiality for fear of being written up by an administrator, but in doing so, they run the risk of destroying any trust that they have built with these students. Students may choose never to share private information with the counselor again. As a result, they may lose the only adult figure in their lives to whom they can turn to get a perspective that is different from that of their peers. Furthermore, other students may also lose trust in the counselor as news of the breach of confidentiality “gets around.”

Judgment calls

Of course, even when they are *not* being asked to tell someone else what a student has shared in confidence, counselors must still make those judgment calls depending on the nature of what the student has disclosed. Sometimes the decision is made for them. For example, it is mandatory for counselors and other school personnel to report all suspected cases of child abuse and neglect, with or without proof.

Most counselors are well-versed in the “classic” reasons that they must breach confidentiality, likely because these reasons are emphasized in almost every counseling graduate program and are found in most ethical codes. The 2014 *ACA Code of Ethics* highlights the need to breach confidentiality when counselors are ordered by a court or when protecting counselees or identified others from “serious and foreseeable harm.” Many states and school systems have gone a step further and have designed strict protocols that counselors must follow in special circumstances, such as when they learn that a student is suicidal. These exceptions to confidentiality must

be communicated to students early and often, along with making them aware that sometimes the counselor will need to share information with parents. School counselors must be particularly adept at explaining these limits to confidentiality without using such a heavy-handed approach that students are afraid to share anything of a personal nature.

As straightforward as these exceptions may seem, in reality they can be tricky. For example, “serious and foreseeable harm” may differ from one student to the next. It must be looked at in a context that considers a minor’s developmental and chronological age, as well as the exact nature of the threat and the setting (e.g., on or off of school property). For instance, there may be a difference in the way a counselor handles a fifth-grader who confides that he sometimes drives his uncle’s motorcycle as compared with a senior in high school who tells the counselor the same thing.

Checking the ethical codes, following an ethical decision-making model and consulting with appropriate school personnel or others are key when choosing a course of action. The necessity for consultation becomes even greater when circumstances are less straightforward, often requiring the counselor to balance student privacy with the needs of parents, the school and the community. For example, counselors may be unsure how to respond when students reveal that they have been intercepting report cards and interim progress reports sent home in the mail. Or that they have been skipping sixth period to go smoke near the fence at the back of school property. Or that they’ve spray-painted the school water tower with their graduation year as a senior prank. To tell or not to tell?

Even the decision “to tell” is not the end of the story, however. Should counselors believe that it is necessary for them to breach student confidentiality, they must do everything in their power to limit the disclosure and educate the parties concerned about the benefits of maintaining student confidentiality. In a perfect world, the counselor would have already introduced parents to the counseling program, the role of the counselor and the importance of confidentiality as a means of building trust with students. Again, in a perfect world, the counselor would have already informed students about the limits of confidentiality and would have made an

extra effort to let the student know about any breach before it was made. After explaining the rationale for the breach, the counselor might want to share with the student the exact content of the information to be released and might even seek input from the student concerning which details should be left in or out.

Diverse populations

Decisions regarding confidentiality may become even more complicated when working with diverse populations, and counselors must be especially mindful of being culturally sensitive when explaining the purpose of confidentiality in the schools. When working with parents with limited English proficiency, the potential for misunderstanding is greatly increased. Consider the following scenario:

Maritza is brand new to your high school, having recently moved here from Nicaragua. You have noticed that she sits by herself in the cafeteria, and teachers have been telling you that she doesn’t seem to have any friends in her classes.

After a few weeks of sending passes for her to come to your office, she finally makes it to the counseling suite. She tells you that she is having a hard time adjusting to life in

America and that she is fearful someone will send her back to her county.

A few days later, at Back to School night, you see Maritza sitting next to her father. You are excited to meet him, so you walk over, introduce yourself as Maritza’s school counselor and say, “I’ve heard so much about you from your daughter.”

Maritza’s father immediately bristles, then turns to his daughter and demands to know what she has been saying to you. Maritza begins to cry, and the father sharply tells you, “In our family, we don’t tell strangers our business. Tell me what she has been telling you!” To tell or not to tell?

Counselors may find that managing difficult ethical dilemmas will bring the need for counselor advocacy to the forefront so that issues can be addressed not only from an individual level but also from a systemic level. The advocacy role for counselors is highlighted in the 2014 *ACA Code of Ethics* in Standard A.7.a.: “When appropriate, counselors advocate at individual, group, institutional and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients.”

Several avenues of advocacy seem possible

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that would help Maritza and all other Latino/a newcomer families in the building. For example, counselors could plan a summer orientation to introduce newcomer families to one another and to families that have resided in the United States for a longer time. Counselors could use this opportunity to help newcomer families become more comfortable with the school, including giving a detailed explanation of the school counseling program and the role of school counselors.

Conclusion

School counselors must keep in mind that the legal right to confidentiality usually belongs to the parents and guardians of minors and not to the minors themselves. Counselors may also find that their ability to protect student privacy is limited by school or district policy. However, counselors have an ethical obligation to keep information disclosed by students confidential whenever possible. After all, trust is one of the hallmarks of developing an effective counselor-student relationship.

Whenever counselors are asked to disclose sensitive information and are unsure how to proceed, they should first consult the ethical codes, follow a sound

ethical decision-making model and seek consultation regarding a course of action. They should try to educate the requester about the negative consequences that might result from a breach of confidentiality, including possible irreparable damage to the counseling relationship. If there is no choice, the counselor should limit the information shared and try to let the student know beforehand what the counselor is going to say. Ideally, the counselor would have already explained the limits of confidentiality to students — both early and frequently in the counseling process — to increase the likelihood of keeping the counseling relationship intact.



For additional information, consult the following standards in the 2014 *ACA Code of Ethics*:

- ❖ A.1.a. Primary Responsibility
- ❖ A.2.c. Developmental and Cultural Sensitivity
- ❖ A.7.a. Advocacy
- ❖ A.7.b. Confidentiality and Advocacy
- ❖ B.1.a. Multicultural/Diversity Considerations

- ❖ B.1.b. Respect for Privacy
- ❖ B.1.c. Respect for Confidentiality
- ❖ B.1.d. Explanation of Limitations
- ❖ B.2.a. Serious and Foreseeable Harm and Legal Requirements
- ❖ B.2.d. Court-Ordered Disclosure
- ❖ B.2.e. Minimal Disclosure
- ❖ B.5.b. Responsibility to Parents and Legal Guardians
- ❖ I.1.b. Ethical Decision Making ❖

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HIGHLIGHTS

- ▶ Spring and Fall admissions
- ▶ On campus and online courses
- ▶ Experienced clinical faculty
- ▶ Cohorts of supportive professional colleagues
- ▶ Clinical specialization
- ▶ Evidence based practice
- ▶ Psychotherapy integration
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JCD Article: ACA326, Trauma Competency: An Active Ingredients Approach to Treating PTSD

Learning Objectives: Reading this article will help you:

- 1) Examine results of meta-analytic studies that support four common elements among effective treatments for clients with trauma-related symptoms.
- 2) Explore therapeutic tasks that counselors can focus on to maximize treatment effectiveness for clients diagnosed with posttraumatic stress disorder (PTSD).

Continuing Education Examination

- 1) Common elements among effective PTSD treatments are cognitive restructuring and psychoeducation, a strong therapeutic relationship, relaxation and self-regulation, and:
 - a) Systematic desensitization
 - b) Exposure via trauma narrative
 - c) Group counseling
 - d) Structured recovery
- 2) Which of the following is a primary tenet of cognitive behavior therapy and an early intervention in treating PTSD?
 - a) Feedback-informed therapy
 - b) Relaxation training
 - c) Stress inoculation
 - d) Psychoeducation
- 3) Helping clients understand and work through physiological dysregulation, as opposed to focusing on anger, sadness or fear, allows the client to understand these emotions as _____ reactions, rather than intentional behaviors.
 - a) Incongruent
 - b) Maladaptive
 - c) Predictable
 - d) Irrational
- 4) Exposure interventions focus on safely working the client through unresolved traumatic memories without overstimulating the client.

____ True ____ False
- 5) The three domains of change in posttraumatic growth are perception of self, interpersonal relationships and:
 - a) Resiliency building
 - b) Philosophy of life
 - c) Recovery
 - d) Resolution

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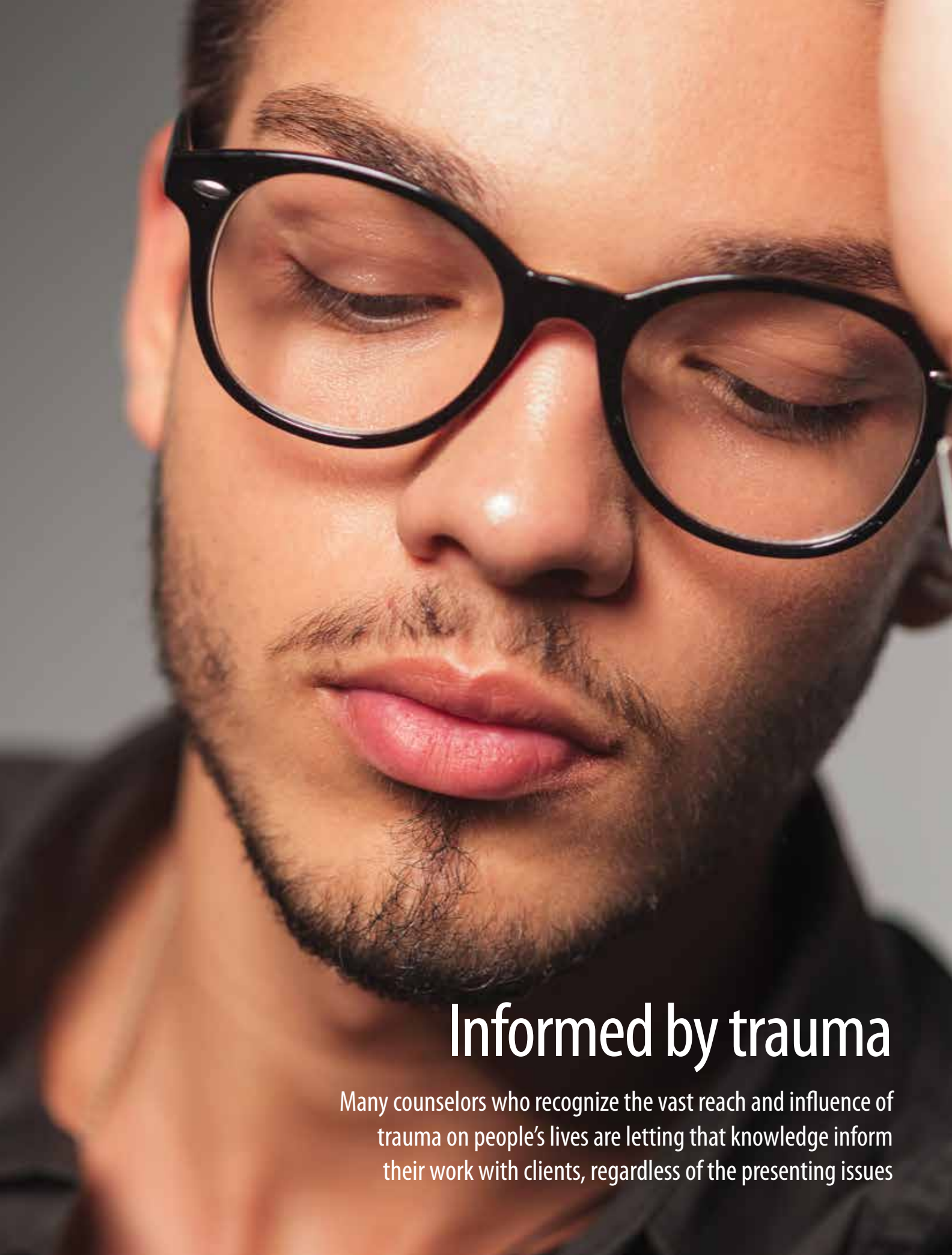
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Informed by trauma

Many counselors who recognize the vast reach and influence of trauma on people's lives are letting that knowledge inform their work with clients, regardless of the presenting issues



By Laurie Meyers

In 1995, the Centers for Disease Control and Prevention and Kaiser Permanente began what would become a landmark study on the health effects of adverse childhood experiences. Over the course of two years, researchers collected detailed medical information from 17,000 patients at Kaiser's Health Appraisal Clinic in San Diego. In addition to personal and family medical history, participants were asked about childhood experiences of abuse, neglect and family dysfunction, such as emotional and physical neglect, sexual and physical abuse, exposure to violence in the household and household members who had substance abuse problems or had been in prison.

Researchers found that the presence of these negative experiences in childhood was predictive of lifelong problems with health and well-being. The more negative experiences a participant had, the more likely — and numerous — these problems became. Another disquieting finding was that adverse childhood experiences were incredibly common. Almost two-thirds of participants had endured at least one adverse childhood experience, and more than 1 in 5 respondents had endured three or more such experiences.

In the decades that followed, this discovery of the prevalence and devastating effects of trauma spurred the development of practices such as trauma-informed counseling, which stresses the importance of recognizing and treating trauma and, most importantly, preventing additional trauma.

Drawing on basic counseling skills

According to the U.S. Substance Abuse and Mental Health Services Administration, programs, organizations or systems that are trauma informed:

- ❖ Realize the widespread impact of trauma and understand potential paths for recovery
- ❖ Recognize the signs and symptoms of trauma in clients, families, staff members and others involved with the system
- ❖ Respond by fully integrating knowledge about trauma into policies, procedures and practices
- ❖ Seek to actively resist retraumatization

In many ways, trauma-informed care involves using skills that every counselor should already possess.

“Remain empathic, open, nonjudgmental and steady. Steadiness is particularly important,” says American Counseling Association member Cynthia Miller, a licensed professional counselor (LPC) in Charlottesville, Virginia, whose practice specializes in trauma. “You don't want to overreact to things a client tells you. But you don't want to underreact either. Screen for trauma at intake. Don't just ask a client if they've ever been abused or neglected. Many clients won't define themselves as victims of abuse or neglect, and if you ask it that way, you'll miss it. Ask behaviorally instead.”

Miller suggests using questions such as, “Has anyone ever hit, punched, slapped or kicked you? Has anyone ever put you down, called you names or made you feel worthless? Has anyone ever touched you without your permission? Have you ever witnessed a violent or upsetting event that really troubled you?”

“If a client responds with a ‘yes’ to any of those questions, ask them if they'd like to share more about it now,” Miller continues. “Help them feel in control of what they disclose and when and how much. Don't make the mistake of thinking you need all the details and then push to get them. You can retraumatize someone that way. Instead, ask them how they think the experience impacted them and if they think it is related in any way to their current struggles.”

“At the opposite end, if they respond to everything with ‘no,’ don't assume a trauma never happened. It may very well be that they're just not telling you about it right now because they don't yet feel comfortable. Stay open to the possibility and rescreen as appropriate.”

When specific questions about trauma don't elicit answers, ACA member Rebecca Pender Baum, a licensed professional clinical counselor in Kentucky who has worked with survivors of sexual assault and interpersonal violence, often asks clients if there is anything they haven't already told her that they think she needs to know. She has found that this approach often helps clients express concerns that they have been holding back.

Jane Webber, an ACA member and LPC in New Jersey who has written extensively about trauma and disaster, often mixes less threatening questions in with questions related to trauma. For example, in the midst of gathering basic background on family history, she will ask clients about events such as accidents or a history of falling. She then works up to questions about physical and sexual abuse. Webber emphasizes the importance of counselors using the same calm, steady tone of voice for all questions to prevent distressing the client.

Webber also finds it useful to tell her clients, particularly those on the younger end of the spectrum, that they can answer her questions via text during the session. She says that sometimes clients are more open to texting about things that they might struggle to express verbally.

Webber urges counselors to be intuitive with clients and look for signs of unexpressed trauma such as sweaty palms, restless movement in sessions and failure to make eye contact.

Miller says that she stays alert "for what I think of as disordered self-soothing," which may include "substance use, self-injury or aggression. Individually, any one of them can be a clinical indicator. As a triad, they're almost certainly covering up an untreated trauma."

A different focus

At first, it may seem strange to treat every client as if he or she is a trauma survivor. However, clinicians who use trauma-informed counseling say that the practice is also about changing the overall focus of counseling by moving away from the "problem" approach. That approach demands, "What's wrong with you? What did you do wrong? What's making you act that way?" says Webber, a lecturer in the counselor education department



at Kean University's East Campus in Hillside, New Jersey. "[Trauma-informed counseling] is a paradigm shift from what is wrong with the client to what happened to the client."

Julaine Field, an ACA member and LPC from Colorado Springs who works with traumatized children, agrees with Webber. Field explains that rather than focusing on changing a client's thoughts or behaviors, trauma-informed care seeks to understand how people react and adapt to experiences.

A trauma-informed counselor helps clients understand where their behavior is coming from by explaining trauma's effects on the brain and emotional regulation, says Field, a counseling professor and coordinator of the clinical mental health track in the Department of Counseling and Human Services at the University of Colorado Colorado Springs. "[Counselors] can also help [clients] understand the real importance of basic self-care, deep breathing, good eating, exercise and that a focus on wellness on a daily basis is the best way to fight the trauma impact and arousal," says Field,

who has also counseled veterans and survivors of interpersonal violence.

A recurrent — and perhaps predominant — theme when talking about trauma-informed counseling is safety. Making the client feel safe and welcome is paramount, say trauma experts. That sense of safety starts with the environment. Counselors should make sure their offices appear warm and inviting, considering everything from comfortable seating to appropriate lighting (neither too harsh nor too dim), says Pender Baum, an assistant professor of counselor education and practicum internship coordinator at Murray State University in Kentucky.

Clients should also feel that they have some control over the counseling process. "Even if you don't know if a client has been through trauma, you can do things as a clinician that communicate to clients that they are safe and in control of what happens in the consulting room," says Miller, an assistant professor of counseling at South University in Richmond, Virginia, who has also worked with incarcerated women.

"Let them determine where they want to sit. Ask if they are comfortable. Give them permission to decline to answer any question they are uncomfortable with and to take breaks at any time during the intake if they start to feel uncomfortable," she suggests. "Pay attention to body language, tone of voice and other cues of emotional distress, and respond to them. Be willing to pause during a session and encourage clients to take a breath, ground themselves or stretch."

Establishing safety

Both Miller and Webber stress that uncovering trauma is not an automatic green light for counselors and clients to start dissecting the past.

"Establishing safety is the most important and, often, the longest stage of treatment," Miller says. "Don't jump immediately into reprocessing, and don't assume that everyone needs to reprocess. And remember that if you take away someone's primary coping skill — however maladaptive it may be — you're leaving them with nothing to soothe themselves when their emotions run high unless you teach them more productive skills."


Webber spends substantial time helping clients build coping skills. She says that deep breathing is the fastest, easiest and most effective way to regulate emotion, but she cautions that there is no one-size-fits-all approach to this technique. Some people like to use counting — breathing in for three or four beats, holding the breath for another three or four beats, and then slowly breathing out, perhaps for six to eight beats.

However, some clients find it stressful to focus on counting, Webber says. In those cases, the counselor and client should just focus on breathing in and breathing out. She directs clients to inhale slowly and to exhale twice as slowly, noting that the slow exhale is what calms the nervous system and helps decrease a person's level of physical agitation.


Another factor in breathing “style” is environment. Some people need to look at something specific such as a wall to focus on their deep breathing, whereas others prefer to close their eyes, Webber says. Counselors and clients should experiment with what works best. It can also be difficult to visualize what breathing from the diaphragm means, so counselors should practice their breathing in front of a mirror so they can better demonstrate it to clients, Webber advises. Because it is hard for people to learn when they feel overwhelmed, she also emphasizes the importance of teaching deep breathing and other grounding techniques to clients when they are calm.

Another grounding technique that Webber uses is anchoring in a safe place. Before asking a client to visualize a safe place, however, she says it is important for the counselor to know whether the client has experienced sexual or physical trauma. In those cases, “safety” for the client might mean hiding behind a locked door, which doesn't provide a healthy, calm image.

“They may not have a happy place,” Webber says. “We might have to create a brand-new place [to visualize], such as a place with no people.” Counselors can help clients visualize their safe places by asking what environments are most comfortable for them.



Counselors who regularly engage in trauma work face an increased risk of vicarious or secondary traumatization.



Webber also uses tapping as a grounding technique. Tapping is a form of bilateral stimulation that helps clients desensitize feelings of trauma and stress. Webber leads clients through deep breathing and asks them to imagine something that is agitating but not overwhelmingly traumatic. Then, she instructs them to use their hands to tap their shoulders repeatedly, alternating between left and right. After about 40 taps, she asks clients to stop and smile.

Clients can also use tapping in public if they are feeling agitated or overwhelmed. Simple and inconspicuous techniques include tapping a foot on the ground three times, lifting a heel in and out of a shoe, or simply looking left and then right repeatedly, Webber says.

Even in the midst of teaching clients coping skills and grounding techniques, their safety is never far from Webber's mind. To avoid retraumatizing clients, she monitors their level of distress in each session, giving them a scale on which 1 represents complete calm and 10 represents overwhelming agitation. Webber begins and ends sessions with the scale. She also pauses and does a quick check within the session if the client shows signs of agitation or arousal. If the client's distress level is too high, Webber stops and does some grounding and deep breathing with the client.

All of the professionals interviewed for this article stressed the importance of counselors receiving supervision or working in tandem with a trauma specialist if needed. “When you start to feel in over your head, you're probably in over your head,” Miller says. “That's

a good time to get supervision or to consult with someone who has more training and experience than you.”

However, there are basic principles of trauma-informed counseling that all counselors should know, Field says. These include:

- ❖ Psychological first aid
- ❖ Mindfulness techniques
- ❖ Breathing techniques
- ❖ Grounding strategies
- ❖ Relaxation methods

“Psychoeducation about the brain and the impact of trauma on the brain is something that all practitioners can do,” adds Field, noting that simply normalizing the effects of trauma can be enormously helpful for many clients.

Helping the helper

Another tenet of trauma-informed counseling is self-care. Immersing themselves in others' problems and pain can take a toll on counselors, and counselors who regularly engage in trauma work face an increased risk of vicarious or secondary traumatization. According to the second edition of the *APA Dictionary of Psychology*, burnout can be “particularly acute in therapists or counselors doing trauma work, who feel overwhelmed by the cumulative secondary trauma of witnessing the effects.”

To continue to treat clients affected by trauma with compassion, counselors must extend some of that same consideration toward themselves. A practice of good self-care can help trauma-informed counselors to safeguard their own mental and physical health.

That is a lesson Jessica Smith, an LPC with a private practice in the Denver area, learned early in her career. “My work used to define me,” says Smith, an ACA member who specializes in addictions and trauma. “If I did a pie chart of where I found meaning in my life, three-quarters of it would have been my work as a counselor when I first started out on this professional journey, but through my burnout and recovery, I've learned that I am so much more than this work. I care about my clients deeply, but I also love and care about myself deeply too.”

“I used to view self-care as a burden — just one more thing to do. But now I see it as an opportunity to show up more fully in my life and the lives of those around me, including my clients.”

Smith now makes self-care a regular part of her day. “I start my day with meditation, journaling and movement in the form of walking, yoga or another form of exercise. I infuse self-care throughout my day through meals, writing, music, mantras, and connections and conversations with other colleagues. I have a mantra that I say before each session, which is, ‘Help me to be a conduit or reed to transmit ... messages to this person in a way that they are able to receive them. Help me to remember that I cannot fix, change or save this person and that I am only one small part of their healing journey on this earth. Give me love, give me hope and give me light.’”

The creative interventions that Smith does with clients — including movement, art, visualizations, writing and breathwork — also serve as a kind of pressure valve, she says. “I’m constantly checking in with my body during sessions, especially when I’m working with [clients who have experienced] trauma, to notice, breathe into and release any areas of tightness and tension.” Smith finds that her body reflects the tension in clients’ bodies. “[I] check in with them about their sensations, then disclose mine as well in order to help model healthy body awareness and connection.”

At the end of the day, Smith clears the office by burning sage and consciously making a decision to let go of any residual trauma or distress. When she gets home, she physically “shakes off” the day before going into the house.

“I end each day with a meditation and gratitude practice where I write down three things I am thankful for that day,” Smith says. “I stretch and do heart-opening yoga poses, then go to sleep.”

Counselors need to have self-care strategies that allow them to gain distance from their work and give them the ability to check out mentally and physically from the responsibilities of being a counselor, Pender Baum says. She has learned to literally put self-care on her calendar.

Additional resources

To learn more about the topics discussed in this article, take advantage of the following select resources offered by the American Counseling Association:

Counseling Today (ct.counseling.org)

- ❖ “Coming to grips with childhood adversity” by Oliver J. Morgan
- ❖ “The toll of childhood trauma” by Laurie Meyers
- ❖ “Traumatology: A widespread and growing need” by Bethany Bray
- ❖ “The transformative power of trauma” by Jonathan Rollins
- ❖ “A counselor’s journey back from burnout” by Jessica Smith
- ❖ “Stumbling blocks to counselor self-care” by Laurie Meyers

Books (counseling.org/publications/bookstore)

- ❖ *Terrorism, Trauma and Tragedies: A Counselor’s Guide to Preparing and Responding*, third edition, edited by Jane Webber & J. Barry Mascari (fourth edition being published in 2018)

Webinars (aca.digitellinc.com/aca)

- ❖ “ABCs of trauma” with A. Stephen Lenz
- ❖ “Children and trauma” with Kimberly N. Frazier
- ❖ “Counseling students who have experienced trauma: Practical recommendations at the elementary, secondary and college levels” with Richard Joseph Behun
- ❖ “Traumatic stress and marginalized groups” with Cirecie A. West-Olatunji

ACA interest networks

- ❖ Traumatology Interest Network (counseling.org/aca-community/aca-groups/interest-networks)

“I live by my calendar, so if it is on there, it becomes just like another required staff meeting or counseling session,” she says. “It’s not negotiable. Admittedly, I can still struggle with this one at times, [but] it’s important not to let work get in the way of your me time.

Get that self-care in whenever you can. It might be closing the door for five minutes and doing some deep breathing or taking a walk around the building. Something to break up the day and get you away from your office.”

It’s also important to engage in activities that don’t have a timeline or deadline and, most importantly, that are fun, Pender Baum says. “I like to kayak, watch movies with my husband [and] read to my daughter. Others might like going for a run, reading their own book [or] soaking in a bubble bath.”

Another self-care strategy that Pender Baum emphasizes for counselors is to avoid isolation. “Developing connections sometimes can involve seeking out professional development opportunities. This helps to keep you connected to the profession, learn new skills and be around other professional counselors without hearing the traumatizing stories from clients.

“For example, just this summer, my mother — a fellow counselor educator and counselor — and I attended a training on finding meaning with mandalas. We not only learned a fantastic clinical skill, but it was very therapeutic [for us] at the same time.”

Pender Baum also stresses the importance of peer support and supervision. “It’s ... important to debrief after particularly difficult cases,” she says. “Have that peer support group, supervisor [or] consultant on hand that you can engage with. Have a mentor or be a mentor to someone.”

Smith participates in two therapist support groups that meet once a month. “Since I’m in private practice, isolation can be a risk, so I do these groups as well as go to lunch or coffee with at least one friend or colleague in the field each week,” she says. “I take time off each month and no longer feel guilty about doing so as I did early on in my career. I try to do a training or workshop quarterly for self-care, connection and to nurture my inner student.”

Pender Baum says counselors need to know themselves. “Give yourself permission to experience the emotions, but also set clear boundaries,” she says. “Know your limits, avoid overtime, commit to a schedule, and recognize and change negative coping skills.”

All counselors should also be aware of the signs and symptoms of vicarious trauma, Pender Baum stresses.

“Vicarious trauma can change one’s spirituality, and this can impact the way we see the world and how we make sense out of it,” she says. “Some counselors experience difficulty talking about their feelings, anger or irritation, an increased startle response and difficulty sleeping. Others might experience over- or under-eating, an ever-present worry that they are not doing enough for their clients [or] possibly even dreaming about clients’ traumatic experiences. Still others might feel trapped in their jobs, lose interest in things they typically enjoy and even [experience] a loss of satisfaction and accomplishment. Some experience intrusive thoughts related to client stories and feeling hopeless.” These are all signs that counselors need to step back and focus on self-care, she says.

Other symptoms include:

- ❖ Chronic lateness or absence from work
- ❖ Low motivation and an increase in errors at work
- ❖ Overworking
- ❖ Avoidance of responsibilities
- ❖ Conflict at work and in personal relationships
- ❖ Low self-image

Pender Baum also urges practitioners to listen to their peers, family members, friends and loved ones if they say they are noticing a change in them. Counselors may be unaware that they are showing signs of burnout, and feedback from others can be helpful in preventing a crash from overwork and stress. ❖

Laurie Meyers is the senior writer for *Counseling Today*. Contact her at lmeyers@counseling.org.

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NEW!

The Secrets of Exceptional Counselors

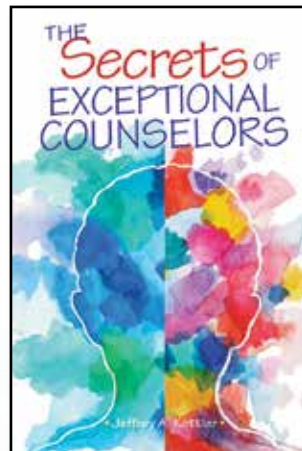
Every profession has trade secrets that are passed on from one generation to the next and counseling is no exception. These cherished lessons include fresh ideas, noteworthy interventions, and even little tricks learned over time that increase both professional effectiveness and personal satisfaction. These unique practices are captured in this entertaining book that discloses the wisdom of master clinicians who discuss their creative breakthroughs, spiritual transcendences, and monumental



Jeffrey A. Kottler

successes. They also reveal some of their most unusual cases, disappointing failures, and disturbing deceptions, and share stories about the clients who have changed them.

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Stories of empowerment

Using narrative therapy, counselors can help clients uncover and give voice to their unique life stories and prepare them to modify the direction of ensuing chapters





By Lindsey Phillips

In 2009, writer Chimamanda Adichie gave a TED Talk on the danger of reducing people to a single narrative, using her own personal stories to illustrate the complexity of individuals. In one of those stories, she revealed how her college roommate in the United States had a single understanding of Africa — one of catastrophe. Adichie, a middle-class Nigerian woman, did not fit this single-story narrative. To her roommate's surprise, Adichie spoke English, listened to Mariah Carey and knew how to use a stove.

Adichie points out that people are impressionable and vulnerable in the face of a story. Stories are powerful, she says, but that power is dependent on who is telling the story and how it is told. “Power is the ability not just to tell the story of another person, but to make it the definitive story of that person,” Adichie says.

Storytelling can also be used to empower people, which is one of the primary functions of narrative therapy. In many ways, the story of narrative therapy began in the late 1970s through shared stories and conversations between Michael White and David Epston. This counseling approach assumes that culture, language, relationships and society contribute to the way that individuals understand their identities and problems and make meaning in their lives.

The narrative approach also separates the person from the problem — a technique that allows clients to externalize their feelings. “The spirit of externalizing the problem is so that the client doesn't see that as something that they can't change,” says Kevin Stoltz, an American Counseling Association member who is an assistant professor of counselor education at the University of New Mexico. Moreover, this approach places clients as the experts in their own lives (see sidebar on page 30).

Don Redmond, an associate professor of counseling at Mercer University in Atlanta and director of the university's Center for the Study of Narrative (CSN), points out that White and Epston's original vision of narrative therapy was not prescriptive. “It really is in some ways theoretical, even though there are specific techniques that

you can learn. It really is about celebrating and appreciating each person's unique story and helping them frame it in a way that is more self-affirming and less self-defeating,” he explains.

(Re)writing memories

Narrative therapy can help clients release the burden of painful memories. Cheryl Sawyer, professor of counseling at the University of Houston–Clear Lake, started using narrative therapy in part because of an aha moment she experienced while watching a scene in the movie *Harry Potter and the Goblet of Fire*. In the scene, Hogwarts headmaster Albus Dumbledore shows Harry the Pensieve, an object that stores thoughts and memories.

Sawyer specializes in trauma counseling and often works with children who are refugees or who have been abused. She wanted to help her child clients release their traumatic memories, so she created a narrative project in which children create memory books. As Sawyer explains, the memory books operate like the Pensieve, allowing the children to unpack their trauma and give it a safe place to live.

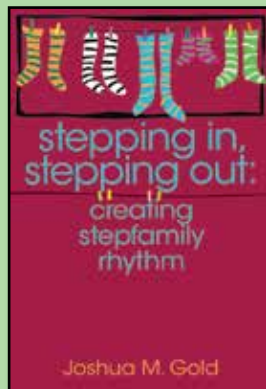
Children do not narrate the episodes of their lives chronologically, Sawyer notes. Instead, their level of trust determines where their stories begin. If they trust the counselor, she says, they will reveal more intimate details (e.g., “I was beaten up at my birthday party”) rather than offering only the generic version (e.g., “I received presents”).

Because children's narratives typically are structured but not sequential, it can be hard to discern cause and effect, says Sawyer, a member of ACA. To overcome this, counselors can have child clients

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place events from their stories on a timeline. This technique allows clients to see the cause and effect, understand their own behavior and possibly project what might come next based on the patterns they notice.

In Stoltz's experience, Adlerian theory and early recollections (an Adlerian process in which counselors instruct clients to remember actual events from their early life) work well with narrative therapy. This is because they help people understand their self-concept and self-identity and make meaning out of the experiences embedded in their lives.

In a classical Adlerian sense, early recollections are defined as memories before age 10, Stoltz says. “The time frame ... is somewhat artificial in some aspects, but in other aspects, it's good to understand the very core of when those first experiences started to come out for people — what they remember, what they really think is poignant that ... shapes their beliefs and their worldview,” he says. Childhood memories are often distorted by one-dimensional thinking because people's perception in childhood is different than in adulthood, he adds. Re-storying involves recalling these early memories and reinterpreting them with an adult mindset that is capable of higher cognitive exploration.

Stoltz is currently applying guided imagery to career narrative stories. As he explains, clients often have a fictional or real-life person they admired when they were young because the person's traits or behaviors matched the way they thought the world should operate. Often, they used this hero narrative to move through life, Stoltz says.

For example, with one client who presented a heroic memory of Spider-Man, Stoltz noticed a pattern: The client kept using the word *conflict* in his narrative. In discussing this pattern, they discovered that the client no longer wanted to let his responsibilities be an excuse for shying away from conflict. So, they worked together to determine how the client handled conflict currently, how the client wanted to handle it in the future and how the client's role models handled conflict.

“Guided imagery is a way of projecting that hero data onto a future career decision or a career transition. And it

makes it more lifelike in the session for the person. It begins to allow them to purposefully imagine and really begin to apply that self-concept to the next step in their career,” Stoltz says.

Stoltz uses narrative data from the career construction interview to develop individualized scripts, including ones focused on supporting client identity, meaningfulness of work and aspects of adaptability and skills. “The narrative approach is always about writing the next chapter, and this is a way of applying the next chapter to an imagined world, a daydream,” he explains.

Pictures worth a thousand words

Words can sometimes fail clients. If clients cannot or will not articulate their stories with words, counselors must be creative and find another way for clients to express themselves, Redmond says. “The more versatile a counselor can be, the better,” he adds.

Sawyer works with some clients who possess limited vocabularies because they have lived on the streets from an early age and haven’t been exposed to higher levels of language. For example, a child might

say, “I’m really mad,” but that statement is insignificant compared with what he or she is actually feeling.

When children don’t have all the words they need to express their thoughts, Sawyer relies on pictures. She asks clients to draw pictures, find pictures on the Internet or even go out and take pictures that support the deeper level of emotion in their personal stories. Often, she will take a series of pictures into the counseling session and ask clients if any of the pictures express how they feel that day and why that image best exemplifies what they are feeling.

Technology is providing yet another avenue for clients to communicate their stories. Sawyer finds that children and adolescents are often more comfortable texting than talking, so she has started using technology as a tool in storytelling. She creates digital narratives by typing the clients’ stories into PowerPoint slides. Then, she gives clients the option of adding music, images or art to depict how they feel. For example, one client added a picture of his father’s death certificate, and another client added a picture of a pair of shoes she was going to send her

sister before her sister was murdered.

Redmond also combines technology and narrative therapy. At Mercer University’s CSN, counseling students interview people in the community and then convert these interviews into digital narratives (approximately five-minute videos) by selecting pictures, art and music to complement each person’s narration of his or her own story. One woman whom Redmond interviewed painted and sang to express her story, and both aspects were incorporated into her digital narrative. Pairing descriptions of her artwork with actual images of it captured her essence more fully than if she had been only interviewed, he adds.

These digital narratives allow individuals not only to rewatch their stories but also to share their stories with others. In fact, one of Redmond’s goals for CSN is to create a digital library that will help individuals going through a difficult time to realize that they aren’t alone.

Taking a back seat

Narrative therapy falls under postmodern theory. “One of the hallmarks of the postmodern approach

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is embracing the fact that there is subjectivity with an individual's perception and what they've been through and not having the counselor come in and be the expert," Redmond says. With narrative therapy, he explains, clients are the ones verbalizing the new or modified narrative of their lives, and counselors only paraphrase or mirror what clients are saying.

Because narrative therapy is client driven, it is more important for clients to understand how they are feeling than for the counselor to understand it, Sawyer says. "[Counselors are] the tool that [clients are] using, the base that they're using, to tell their stories for themselves," she explains. Clients must be provided with a safe space where they can share their stories and learn to express their feelings about what happened.

As a volunteer with Bikers Against Child Abuse, Sawyer often attends court cases involving children who have been abused, and she has observed children's frustration when lawyers interrupt or guide their stories in answer to a specific question. For Sawyer, this observation further underscores the importance of allowing clients, not counselors, to direct and narrate their stories. As she points out, counselors are facilitators for the client's story, so their job is to listen and help the client structure the order of the story, not the content.

Stoltz has found that the process of deconstructing and reconstructing the elements of a client's story is often challenging, particularly for counseling students. To demystify this process, in 2015, Stoltz, along with Susan Barclay, published a guidebook, *The Life Design ThemeMapping Guide*, that provides counselors with a process for deconstructing narrative data, developing specific themes for the career construction interview and helping clients reauthor their stories. For the past five years, Stoltz has used this technique to train students to deconstruct and theme elements together.

Taking a back seat and allowing clients to guide the session can be particularly difficult for new counselors because they want to feel that they are accomplishing something, Stoltz says. They want to sense that the client has made a decision and is moving in a direction. Drawing on

Narrative approaches

As explained in the fifth edition of *Counseling and Psychotherapy: Theories and Interventions*, edited by David Capuzzi and Douglas R. Gross and published by the American Counseling Association, narrative therapy is based on the following beliefs:

- 1) Clients are not defined by problems they present in counseling.
- 2) Clients are experts on their lives, so in counseling, judiciously seek their expertise.
- 3) Clients have many skills, competencies and internal resources on which to draw when impacting change and growth.
- 4) Therapeutic change occurs when clients accept their role as authors of their lives and begin to create a life narrative that is congruent with their hopes, dreams and aspirations.

James Prochaska and Carlo DiClemente's Stages of Change model, Stoltz reminds counselors that they're "raising awareness now. You're in the beginning of the change model. You're in the contemplation stage or precontemplation stage. You're not looking for movement. You're looking for insight or awareness, the aha moment."

A voice for marginalized, multicultural populations

With narrative therapy, clients inform counselors about their world, values and beliefs. In fact, early recollections provide counselors with an inside view of the client's culture, Stoltz says.

Within this dynamic, a counselor's culture and values may differ from the client's, but counselors should not place cultural judgment on what clients have done, Sawyer says. For example, clients might disclose that they have offered sex in exchange for food, or they may use profanity in telling their story, but counselors must refrain from passing judgment, even if they think this act or language is hideous or immoral based on

their own cultural perspective. Clients must feel safe to use their own language and words to freely tell their stories, Sawyer adds.

Redmond agrees that narrative therapy is compatible with cross-cultural environments because narrative counselors do not presume to know and tell clients about their problems. He also realizes that too often, the stories of marginalized individuals remain unheard. One of Redmond's inspirations for creating CSN was StoryCorps, an oral history project that allows people to record their stories in a studio by having a family member or friend interview them. The recordings are then archived at the Library of Congress. Through CSN, Redmond expanded the project to include marginalized populations (e.g., people who are homeless, refugees) who do not readily have someone available to interview them and record their stories.

Redmond believes the community plays a significant role in narrative therapy. Therefore, CSN's purpose is both to allow counselors to practice their listening skills and to provide a service to the community by letting people who are marginalized know that they are valued. Even though the CSN interviews are not considered official therapy, most people would agree that the simple act of telling one's story can be therapeutic, Redmond says.

Redmond's personal story also played a role in the creation of CSN. Besides the fact that he has always enjoyed stories, Redmond had two professional experiences that strengthened his belief in the power of narrative therapy. First, in his role as a supervisor at Hillside in Atlanta, a facility that serves children with severe emotional behavior disorders, he discovered that the children with the most severe behaviors and who had been at the facility the longest also possessed the most strengths. This observation made an impression on him, especially considering all the negative messages directed at these children, many of whom had been abused and were in and out of foster care.

The second experience occurred when Redmond was an access clinician at a community services board. Many individuals were at this facility under court order or because they were dealing with mental health issues. While

conducting intake interviews, Redmond amused himself by writing down the clients' strengths (e.g., intelligent, strong work history, sense of humor, family support). At the end of the interview, he would tell the clients the strengths he had jotted down and then would ask if they wanted to add anything. He often witnessed powerful reactions from the clients, including those who cried and said no one had ever told them that they had strengths.

These two experiences reinforced Redmond's belief that "people start creating negative self-stories, and they start to only believe the negative images, and then they forget about the strengths that they have." Therefore, Redmond advises counselors never to forget to account for the strengths of their clients, no matter the difficulty of the case.

The cultural awareness gleaned from narrative therapy also applies to clients, allowing them to question their own cultures. Often, Stoltz says, the difficult part is relating the memories and stories back to the client's present life. Some clients grasp this concept more easily than others, and some struggle to understand

how childhood events are still affecting them as adults. The latter scenario is challenging. "Early memories really are a good tool to have to be able to talk to people from different cultures because [there are] stories in every culture. ... Memories are a story, and [they are] a way of relating that whole story back to the person," he says.

Validating narrative therapy

Critics of narrative therapy often question how counselors objectively measure narrative techniques, which are subjective. "I think we're in the infancy of starting to measure these kinds of things. I think we're just beginning to rediscover some of the things that have been helpful in mental health counseling, and we're applying those as new techniques to the career narrative area," says Stoltz, who served as chair of the research committee for the National Career Development Association, a division of ACA. At conferences, counselors are discussing how the narrative approach works, and they are doing outcome research that says it works, but they are not yet validating the process, he adds.

"You cannot quantify emotion," Sawyer acknowledges. She and her colleagues attempted to measure narrative approaches by administering a pretest and posttest to children who had suffered trauma. They found a valid instrument and administered it in the children's native language, but the formality of the instrument and the fact that the counselors had not yet established a relationship with the clients caused some clients to leave prematurely. Based on this experience, Sawyer decided not to administer the posttest and concluded that sometimes narrative therapy is not about research; it is about clients and their needs.

The best method Sawyer has found for measuring the success of narrative therapy involves having clients point to shapes (e.g., small, medium and large circles) to indicate how big their problems are both before and after counseling sessions. Using this method, she has found that narrative therapy has a positive effect because for most children, the representative shape decreases in size at the end of the counseling sessions. However, because counselors cannot

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account for all variables — if court is over, if the client is living in a home with 14 other children, if the client has learned to speak English and so on — it is impossible to know whether clients have improved strictly because of narrative therapy, she points out.

Redmond is a proponent of mixed-methods research because quantitative research (e.g., a Likert-type scale) provides more breadth than depth, whereas qualitative research provides the depth. In addition, they complement each other: Quantitative research can provide counselors with great ideas for qualitative research and vice versa. Redmond recommends first using quantitative research, such as a survey, because clients find it less threatening and less personal, but it will still get clients thinking about their experiences. Then, counselors can ask clients the magic question: “Is there anything you haven’t discussed that you would like to talk about?”


Stoltz has discovered that finding thematic codes for categorizing narrative data is one way to measure narrative techniques. For example, people who engage in storytelling about traumatic events in their lives tend to integrate these life events into meaningful stories and report higher life and career satisfaction.

“Preliminary evidence is beginning to show that when trained people read these stories, they come to the same conclusions,” Stoltz says. “That’s an important first step in validating ... this process.”


In addition, digital narratives may provide opportunities to quantify narrative interventions in the future, Redmond says.

Integrating narrative practices

Narrative therapy is not for the lightweight, and it is not as easy as it sounds, Sawyer says. In fact, self-doubt can prevent counselors from using narrative techniques, she points out. To avoid this, counselors need practical experience. Just taking one course or workshop or reading a book on the topic won’t mean that counselors will know how to use the approach correctly. Instead, Sawyer argues that counselor training should involve a holistic approach in which counselors



For Stoltz, it makes sense to apply narrative therapy to career counseling because there is always a story behind one’s career.



expose themselves to the topic not only through courses, books and articles but also by practicing under supervision and processing all along the way.

Also, some counselors are hesitant to incorporate mental health-based approaches if their training is in another specialty such as career counseling. Stoltz, however, stresses the importance of taking an integrated perspective because people have multidimensional experiences that are not mutually exclusive. “Career counseling is often seen as limited to the career dimension, but it is really counseling with a career goal in mind,” he says.

For Stoltz, it makes sense to apply narrative therapy to career counseling because there is always a story behind one’s career. Furthermore, many people spend eight to 10 hours working every day, and work stress is a significant contributor to a person’s well-being or absence of well-being, he says. Despite this, counselors are generally not incorporating work aspects into mental health, he points out.

Thus, Stoltz argues that counselors “need to rethink [their] specialization construct.” Unfortunately, it is easy for counselor educators to design courses that address a certain standard (e.g., a career counseling course, a trauma course, a multicultural course). However, when counselor educators create stand-alone courses, students often move from one course to another without integrating those courses, Stoltz says. To avoid this, he incorporates basic counseling skills alongside career counseling because students must learn to respond to content

and meaning before they can help a client deconstruct a story.

Sawyer’s counseling program at Houston–Clear Lake integrates narrative therapy into the curriculum by introducing narrative therapy as a counseling tool and working narrative techniques into multiple courses. “It is not the only way to counsel but ... like how everybody knows how to do Rogers, everybody knows how to do Gestalt ... all of my students know how to do CBT [cognitive behavior therapy] and trauma-focused CBT, and they all know how to do narrative counseling,” she says.

Stoltz agrees with expanding counseling areas, but he also worries that as counseling training becomes broader, counseling programs are finding it difficult to retain depth. Counseling students need to understand both the academic jargon and the practical training associated with those terms, he stresses. “Re-storying needs to be accompanied with a practical, pragmatic application of what that looks like and what that process is,” he says.

Stoltz is helping to bridge this gap by incorporating experience work in his classroom, which is a technique modeled after Mark Savickas’ pedagogical practice. For example, a counseling student might do a case study and follow someone through a career intervention, or a career story, and present this constructed story to the class.

Redmond finds that counseling students infrequently have many opportunities to train specifically in narrative therapy or narrative studies. Currently, students in his program are introduced to narrative therapy under the umbrella of postmodern approaches in a counseling theories course, but his goal is to have students do more specialized work in narrative therapy in the future. As a step toward achieving this goal, he will be working this fall on a proposal for a narrative certificate program.

Authoring the next chapter

Stoltz acknowledges that misinterpretation or a unitary interpretation of a client’s story is one of the pitfalls of narrative therapy. “[Counselors] feel like [we’ve] got the inside track on this because [we] have this psychological knowledge, this counseling

knowledge, and [we] have to be careful with that,” he warns.

Often, counselors will make up their mind about what the story means to the client. But the counselor’s job is to test, not to interpret, Stoltz says. Counselors should make the client aware of what they see and test that theme or theory with the client while still respecting that it is the client’s story, he explains. The client is the one who has to live the life and rewrite the story; the counselor’s job is to help the client accomplish this.

Adichie reminds us that “stories can break the dignity of a people, but stories can also repair that broken dignity.” Narrative therapy provides clients with a safe space to tell their stories. With a counselor’s guidance, clients can slowly reject the negative stories and stereotypes that create an incomplete or inaccurate representation of who they are as individuals and replace them with stories that empower them to take control of their lives and regain their humanity.

Stories are powerful, but the person holding the pen is the one who controls the story. Revision is key when writing a novel, and this holds true in narrative therapy as well. People first have to understand and narrate their stories in order to rewrite them and become the authors of their next chapter. ❖

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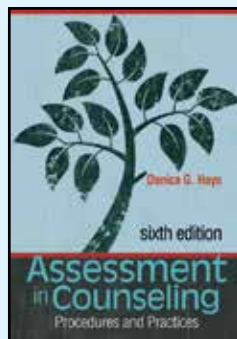
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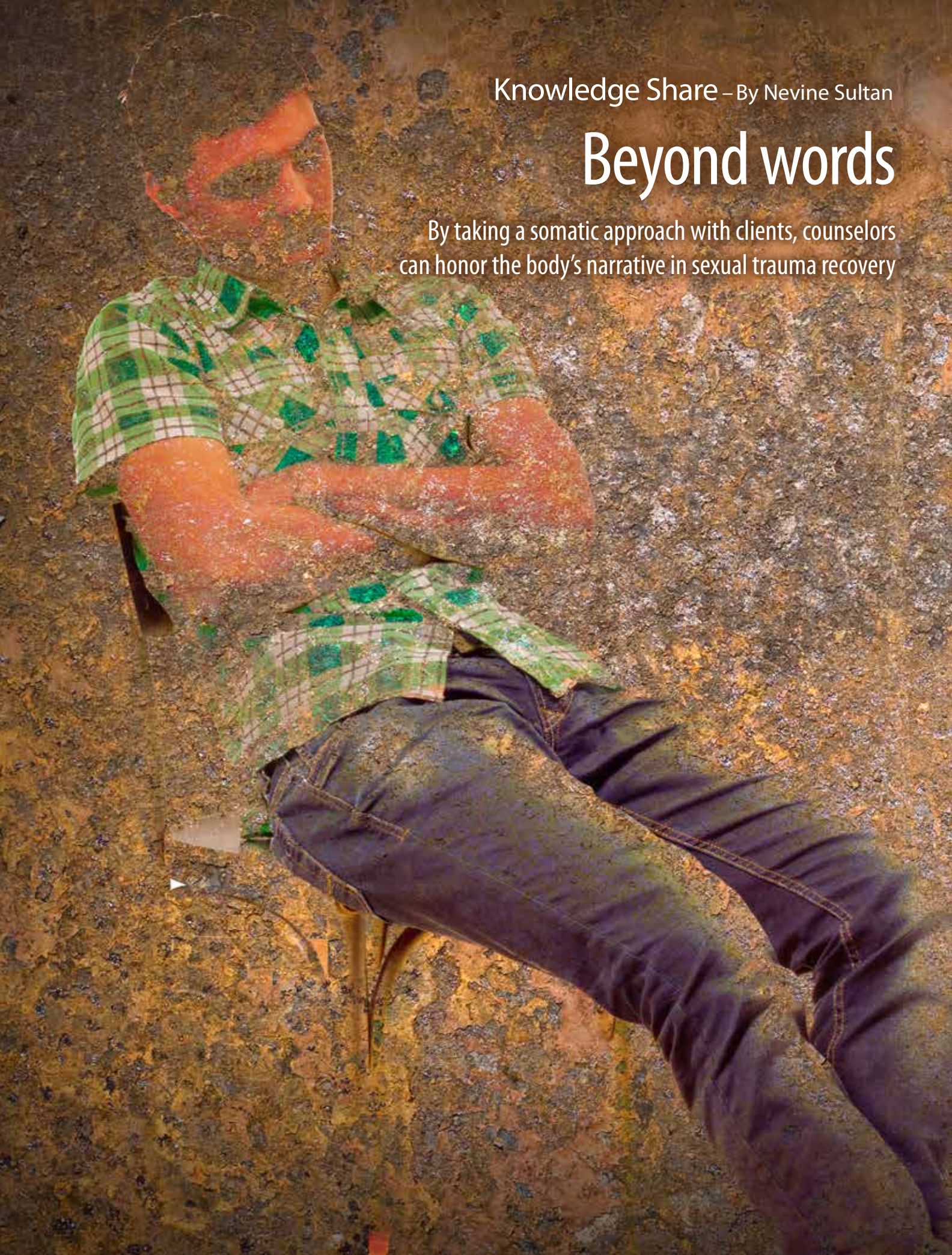
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Knowledge Share – By Nevine Sultan

Beyond words

By taking a somatic approach with clients, counselors can honor the body's narrative in sexual trauma recovery



Attempting to work from a purely cognitive or emotional perspective with clients who have experienced sexual trauma is like trying to build a sturdy house without laying down a solid foundation. Facilitating recovery from sexual trauma demands the inclusion of the site of the original wounding — the body.

A clinical vignette

“Jerry” arrives seven minutes late for his intake appointment. He appears disoriented and confused.

“Please,” I say, inviting him to take a seat. When our eyes meet, he turns his gaze to the floor and explains, “I think I stopped at a gas station on my way here.”

Jerry’s face is flushed and his nostrils are fluttering. Although his head seems to be the most active part of him, I am drawn to Jerry’s feet, legs and hands. The rigidity in the lower half of his body is intense. Jerry’s left foot is twisted outward in a painfully supinated position. His hands are imprisoned beneath his thighs, and his shoulders are hunched forward. The word *concave* comes to mind. I feel a sense of hollowness in my core as I realize that Jerry is holding his breath like a dam straining to hold water that might cause irreversible damage if released all at once.

We talk briefly. Jerry tells me about his anxiety, the panic attacks that have besieged him up to twice daily over the past few months, his ceaseless hypervigilance, the memories that haunt him, the persistent need to wash his hands and the nights dotted with brief slumber from which he is jarred awake by horrific nightmares. “I’m also having problems with my girlfriend,” Jerry says. “I know I can trust her. It’s just ... I can’t shake that feeling.”

As Jerry speaks, his voice is jittery and his lips tremble. His breathing shifts from closed to ragged. “I was out taking a walk in my neighborhood one night. A guy drove up to the sidewalk and asked for directions to the community pool.” Jerry’s pitch lowers, his articulation becomes less sharp, and he drifts inside himself. I shift in my chair to gently facilitate his return to the here and now. He looks up before continuing.

“As soon as I started talking, he got out of the car, opened the door to the backseat, and then ... I don’t know. It

happened quickly.” He pauses. “I woke up in a hospital. My wrists were really bruised.” Jerry scans the room with his eyes, which are filling with tears. “I couldn’t save myself.” He weeps, pulling his hands out from beneath him and rolling them up into fists.

My stomach clenches, and I feel a sting in my eyes. I am all too familiar with this narrative. Many of my clients who have suffered sexual trauma describe similar experiences of numbing and freezing and an overwhelming sense of self-betrayal. I take a deep breath and redirect my attention to Jerry, who is still sobbing. I give him a few minutes. As he recovers from his outburst, he returns to holding his breath.

“Jerry?” I say gently. He looks up. “Thank you for trusting me with that. See if it’s OK to exhale. Slowly.”

Understanding dysregulation

Every word that Jerry says matters. I note his narrative. It is significant. I also note the *paranarrative* — the cauldron of sensations, emotions and racing thoughts bubbling beneath the surface of his quivering demeanor. This agitated vessel is holding a fusion of fear, isolation, shame, avoidance, mistrust, physical and emotional numbing, negative beliefs, impulsivity, diminished agency and an outright inability to tolerate the present.

While Jerry’s thoughts and emotions are overly active, his body is entirely ignored. Consequently, he is caught in the unconscious frenzy of persistent fear and some terribly unforgiving stories: *The world is dangerous. I will never be safe. I can’t protect myself.*

The harm Jerry has endured did not compromise his thinking or his emotions alone, however. Jerry has suffered a severe wounding to his body; hence, his collapsed posture, his irregular breathing and his restricted movement, coupled with his overall sense of being

overwhelmed and his inability to maintain a state of calm.

As French phenomenological philosopher Maurice Merleau-Ponty pointed out in his seminal text, *Phenomenology of Perception*, our bodies are the agents by which we exist in the world. They are also the receptacles of memories that, often vanished from our conscious awareness, are still deeply etched within our being. When those memories are triggered, we experience suffering at a highly existential level that transcends consciousness. Facilitating the recovery of clients who have experienced sexual trauma must include opportunities for repairing connections with all dimensions of their being.

John Hughlings Jackson, known as the “father of English neurology,” outlined a human nervous system composed of three parts: social, sympathetic and parasympathetic, which has since inspired Stephen Porges’ polyvagal theory. Jackson’s model is hierarchical: The higher elements inhibit the lower elements. When a higher element on the hierarchy fails, a lower component takes over.

The highest element of the nervous system is the social one, responsible for relational contact and communication. Lower on the hierarchy is the sympathetic nervous system, which kicks in when we experience a disturbance in our inner or outer environment, thus activating our fight/flight/freeze/dissociate response. Should we not fight or flee, we plunge into freezing, immobility and dissociation. Unless the parasympathetic nervous system is reactivated, we remain frozen, incapable of responding to our environment.

Paradoxically, nonthreatening surprise situations are likely to elicit a

sympathetic nervous system response, whereas threatening situations are likely to elicit a parasympathetic response, which is why many of us freeze or dissociate when confronted with a seemingly hostile situation. A healthy nervous system is one that self-regulates through a balance of sympathetic and parasympathetic functioning — that is, an arousal-activation event is followed by a period of rest and digest. An unhealthy nervous system, on the other hand, remains in either hyper- or hypoarousal, giving rise to startle, panic, hypervigilance, restlessness and emotional flooding, or to emptiness, exhaustion, disorientation, dissociation and emotional numbing, respectively. Clients who have not resolved traumatic events are often stuck in hyper- or hypoarousal.

In the aftermath of a traumatic event, survivors are likely to develop generally maladaptive coping symptoms that offer temporary relief from dysregulation. These coping symptoms include various process and substance addictions, obsessions and compulsions, and self-harm. Regardless, clients suffer the following interruptions:

- ❖ Physical/perceptual (inaccurate kinesthetic reactions to perceived threat, anxiety, dissociation, collapse)
- ❖ Contextual (difficulty perceiving and making sense of surroundings)
- ❖ Emotional (fixation on fear, rage or sadness)
- ❖ Cognitive-behavioral (intrusive, racing thoughts; memory loss; self-destructive patterned behavior)
- ❖ Spiritual/existential (loss of sense of self)

Jerry tends to cycle between hyper- and hypoarousal, as evidenced by his frequent experiences of hypervigilance and panic attacks, and his often collapsed and frozen posture. When agitated, he attempts to manage his dysregulation in a number of maladaptive ways, including engaging in impulsive (e.g., breaking up and making up with his girlfriend repeatedly) and compulsive behaviors (e.g., continually washing his hands).

Although traditional cognitively and emotionally oriented psychotherapy approaches may help Jerry ease some of these coping behaviors, they do not include methods for addressing his dysregulation. Working with Jerry’s physical process allows me to help him identify when he is in hyper- or hypoarousal and bring himself back to what leading neuropsychiatrist and interpersonal neurobiologist Daniel Siegel refers to as one’s “window of tolerance,” or the zone in which our arousal state is balanced.

Honoring the somatic narrative

The somatic approach to healing trauma was inspired by a phase-oriented model for treating trauma and dissociation that was established in the early 20th century by French psychotherapist Pierre Janet. The somatic approach requires an understanding of how nervous system dysregulation is activated as a consequence of trauma and which parts of the body and brain are involved. The counselor uses this information to help clients create a sense of safety, to facilitate clients’ use of internal resources to regulate arousal and enhance self-efficacy, and to help clients address traumatic memories and



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explore novel ways of being in the world. Interventions include focus on nonverbal experience, kinesthetic awareness and reshaping body movement.

In the aftermath of his traumatic assault, Jerry's ability to organize his experience was compromised, resulting in dysregulation of arousal, challenges tracking his surroundings and increased cognitive and emotional processing. This sent his thoughts and feelings into overdrive, making it difficult to control his impulsivity. With his inability to self-regulate, Jerry is virtually incapable of remaining connected with his present moment, and specific trauma-related (and sometimes neutral) stimuli can trigger an immediate impulsive response.

According to Pat Ogden, the pioneer behind the popular attachment-based somatic approach to healing trauma known as sensorimotor psychotherapy, a primary task faced by counselors working from a somatic approach is to help clients create a balance among the various processes used to organize experience. This is done using a bottom-up model that views human experience as an initially sensory process that informs emotion, which then informs thought and behavior. Focusing on the here and now is especially important when using a body-centered approach because it allows the counselor to address how a past event is manifesting in the present.

Finally (or perhaps first and foremost), when working with the somatic dimension, high levels of therapist presence and attunement are needed to support a therapeutic alliance with appropriate boundaries that is built on safety and trust.

Creating shared space

Essential to facilitating Jerry's connection with his physical process is my personal embodiment — that is, my ability to be in contact with and present in my own body. By anchoring myself in my body and my present-moment experience, I am better able to create an empathic space for our encounter.

I use my sensory experiences to inform the therapeutic process and guide me toward a well-rounded understanding of how Jerry exists in the world based on how he exists in the therapy room. Understanding the experience of my body

when I am in contact with Jerry helps me reach out within our intersubjective space with the deepest respect for his pace while acknowledging that I am affected by his experience. From this place of compassion and empathy, sharing and being, and phenomenological engagement, an integrative somatic process begins in which I serve as a bridge between Jerry and the rest of the world.

"When you are ready," I say to him in gentle invitation.

Organizing the client's experience in the here and now

I listen to Jerry's verbal narrative. I also attune to the story his body is telling and how my own body is receiving that. What body postures does Jerry fall into as he recounts specific parts of his story? What gestures accompany certain words, phrases or recollections in the here and now?

Such physical manifestations are indicative of how Jerry's body has encoded certain events implicitly. Jerry is physically manifesting content from his implicit (unconscious), somatic memory of the traumatic event that may or may not be congruent with his declarative (conscious) memory. Keeping in mind the fallibility of declarative memory, working from a somatic approach supports access to Jerry's implicit memory, which offers us additional insight into his experience.

Attending to Jerry's somatic narrative, I notice that his fists hold the highest energy. My own fists are wound so tightly that I can feel my nails digging into my palms. I also notice that I am holding my breath in anticipation. I release my breath, unfold my fingers and share some observations with Jerry in the form of brief contact statements designed to enhance his awareness.

I also pose exploratory questions. "I'm noticing that as you talk about feeling incapacitated in the moment you were grabbed, your hands are balled into fists. Would it be all right to bring your attention to your hands for a moment?" Helping Jerry consciously connect with the most reactive part of his body invites his capacity to self-witness and be self-aware. This activates the prefrontal cortex

that, according to body-centered trauma expert Bessel van der Kolk, is responsible for emotion regulation, cognitive and social behavior, and decision-making.

As Jerry accesses his past experience in the here and now from a nonreactive place, he is better able to observe it, recognize that it happened in the past, notice how it is manifesting in the present and identify new ways of understanding it. Next, we work to identify the emotions that arise with the declarative and implicit memories of the experience and any thoughts that accompany the physical and emotional manifestations.

"What are you sensing in your fists right now?" I ask. "Examples of sensation are tingling, tightness, cold, heat."

"They're stuck," Jerry says. "I can't do anything with them."

I ask Jerry to name the feelings that accompany that sense of stuckness.

"Examples of feelings are anger, sadness, guilt, fear. 'I feel ...' Can you fill in the blank?"

Jerry stares at the ground. "I feel ... angry." He begins to weep inconsolably. "I'm so, so angry." He drops to the floor and curls into a fetal position. I give him a few minutes to be where he needs to be, to experience being balled up and angry.

"I'm so mad at myself. I didn't save myself. Who does that?" I recognize that I didn't

have to invite Jerry to reflect on any thoughts accompanying the emotion and the sensation; the thoughts are emerging on their own.

Minutes later, Jerry is still holding his fists, but his tears are subsiding. I grab a box of tissues and sit on the ground near him, close enough to offer the nonphysical support he may need. I pull out a tissue and drape it gently over his left fist. He flinches and opens his eyes, looking straight ahead.

I wonder if it might be helpful to invite some awareness around how he is organizing this experience. "What are you holding inside your fists, Jerry? And what is that doing for you?" Jerry continues to look out into the ether. "Your fists," I prod gently. "If your fists had a voice and could speak, what would they say? 'I ...' Can you fill in the blank?"



Nevine Sultan

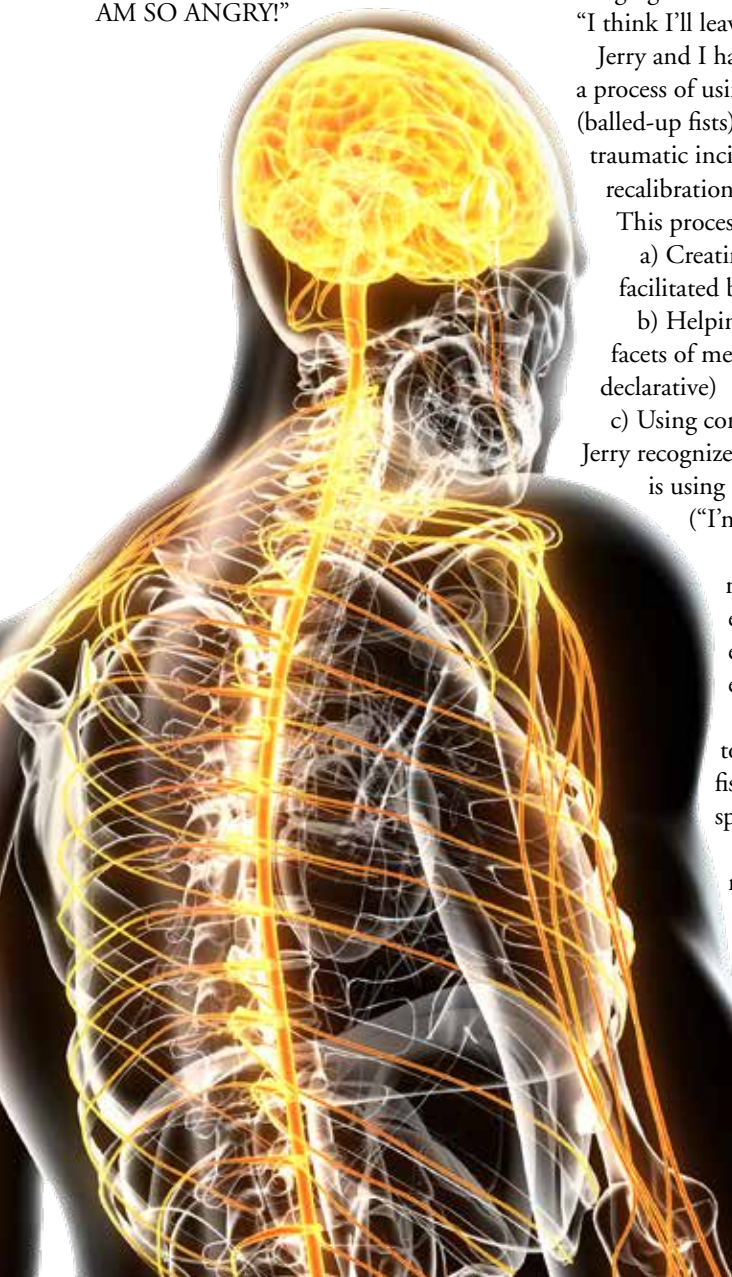
Jerry is silent for a few seconds. "I ... I am ..."

"Yes, Jerry. Keep going," I encourage him.

"I am ... very angry," he offers meekly.

"Is that what the anger inside of your fists sounds like?" I nudge gently. Jerry shifts slightly in his fetal position and then stops. "What does your body need to do right now?" I ask. "Expand? Contract? Walk away? Move closer? Is it OK to explore that need?"

"I think I need to move," Jerry says. Without further invitation, he sits up. His upper body is still collapsed, and he seems undecided. I invite him to attend, once again, to what his body needs. Jerry inhales a little more deeply, expands moderately with his intake of breath, tightens his fists further and bellows, "I AM SO ANGRY!"



"Say that again," I urge. "Give your fists the voice they need."

"I AM SO ANGRY!" he screams, over and over. Twenty times. Thirty times. "I WILL NEVER LET ANYONE DO THIS TO ME AGAIN!" Jerry says even louder, holding his fists chest high and shaking them like he has someone by the collar.

Once Jerry has experienced a full release of energy, his tight fists unfold, although with some reservation. "Would it be OK to let go of the rest of that?" I invite.

Jerry's eyes close, and I realize he may be unwilling to let go. I offer a compromise. "You don't have to let go of your anger forever," I say. "Maybe you can leave it in a safe place so that you can have it back whenever you want it."

Jerry seems open to this idea. After some deliberation, he looks at a print hanging on the wall behind me and says, "I think I'll leave it behind that picture."

Jerry and I have just worked through a process of using an implicit memory (balled-up fists) connected with his traumatic incident to initiate a recalibration of his nervous system.

This process involved:

- a) Creating a shared space facilitated by my presence
- b) Helping Jerry identify different facets of memory (implicit and declarative)
- c) Using contact statements to help Jerry recognize the orienting patterns he is using to organize his experience ("I'm noticing ...")
- d) Inviting Jerry to name his sensory, emotional and cognitive experience ("What are you experiencing ...?")
- e) Allowing Jerry's body to tell its narrative ("If your fists had a voice and could speak ...")
- f) Exploring modification of Jerry's orienting patterns ("What does your body need right now?") and experimenting with new ways of being
- g) Restoring empowering actions ("Give your fists the voice they need.")

The next step involves making sense of our process. The hope is that Jerry will use his new understanding of his experience to make new choices informed by the here and now.

Creating meaning and energizing change

"What was that like for you?" I ask.

"I don't know," Jerry says. "I feel like a heavy load has been lifted." I nod. "From these," he continues, raising his hands.

I acknowledge and affirm Jerry's reflection. "Those fists were holding on pretty tight. What did it mean to hold tight?"

"I think ... I felt in control."

"Can you say more about that?"

"Yeah. Like I wasn't going to lose it, I guess."

I feel that Jerry and I are in a safe enough place for my next question. "What would happen if you allowed yourself to completely lose it?" Jerry clenches. "OK to exhale?" I invite.

Jerry releases his breath slowly. "I don't know."

"Jerry?" I invite him to make brief eye contact with me. "I'm not sure I buy that." I smile gently. "What would happen?"

Jerry thinks but maintains eye contact. "I mean, I just lost it, right?"

I offer a perspective: "Seems like you trusted yourself with that too."

"I did," he says solemnly.

"What is it like for you to trust yourself?" I ask. "I ...' Can you fill in the blank?"

"I feel pretty big right now."

"Hmm. What does big look like?" I invite. "Can you show me?" Jerry lifts his body and expands his chest. Although he does this slowly and with seeming caution, I am aware that he has given himself permission to explore a place beyond his wound. I open the door for a final inquiry that will help Jerry take what he has learned about resourcing himself outside of the therapy room: "What might you do with that bigness, Jerry?"

Working through roadblocks

Accessing and working with certain memories in the here and now is not always a straightforward process. In Jerry's case, he sometimes exhibits an aversion to being in the present. For example, although Jerry shows relative

ease connecting with his anger, in a later session he experiences great difficulty accepting his shame.

Jerry's resistance manifests, initially, as indirect eye contact and fixation on the ground. Once we begin exploring this and Jerry identifies the emotions and thoughts connected with it, he manifests an outburst of physical agitation that is marked by twitching in his chair until he falls to the ground.

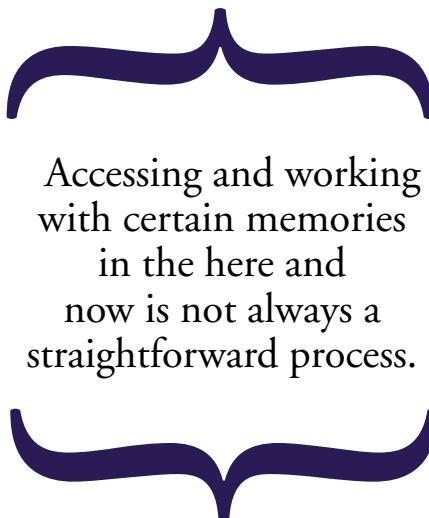
I invite Jerry to remain seated on the floor and connect with the ground (using a process we call *grounding*), which helps him feel connected to and supported by something outside of himself. Next I ask him to explore his center of gravity by way of a process called *centering*, which brings his attention back to his physical experience. Finally, I suggest *containment*, a self-holding exercise designed to facilitate self-regulation and awareness of one's boundaries and overall physical presence.

Because of their focus on the physical, these exercises shift clients' attention from the self-destructive emotional and cognitive narrative to their internal resources. With this, the counselor is tasked with pacing the session so that the client is not overwhelmed. Introducing these safety-enhancing exercises is often helpful as sexual trauma clients experience the need to recalibrate from the potentially overpowering experience of confronting their trauma.

Establishing a time frame for the therapeutic process

Clinicians working from a somatic approach are highly aware of the challenges of creating time parameters for their therapeutic work. On the other hand, it is not uncommon for clients to ask, "How long will I be in therapy?" My response is that it depends on a number of factors, including:

- 1) Whether the traumatic event was a single, first-time incident or is recurring
- 2) The client's developmental history (i.e., milestones, attachment patterns)
- 3) The client's current coping strategies
- 4) Systemic factors (i.e., family, community and broader social support)
- 5) Client openness to working with the body
- 6) Therapist consistency and the quality of the therapeutic alliance



Accessing and working with certain memories in the here and now is not always a straightforward process.

That said, somatic therapy tends to be time intensive, unlike, say, brief solution-focused or cognitive-behavioral work. Jerry attended weekly 80-minute therapy sessions for approximately 10 months, followed by biweekly 50-minute sessions for three months. He is currently coming in for monthly 50-minute check-ins.

Although Jerry has not forgotten his traumatic incident, he has learned how not to be hijacked by memories, how to self-regulate when confronted with somatic, emotional or cognitive triggers and how to tap into internal resources (including his body) to address present-moment needs.

Closing reflections

Embracing a somatic approach in working with Jerry's sexual trauma engages his verbal and nonverbal narratives, opening a door to reshaping his way of being in the world and catalyzing new intentions and experiences. It also helps us focus on *what is* versus *what was* or *what might be*.

Working in the present enhances Jerry's awareness of who and how he is in the world, what he does and how he does it, and how remaining stuck in the past or allowing himself to be hijacked by the future are choices he can modify as he works to reconnect with his window of tolerance. Being aware brings present-moment possibilities and options center stage. The emphasis is no longer on irreversible past or anticipated future experiences but on what is happening in the here and now.

Thus, clients take responsibility for their needs, feelings, thoughts and actions.

Taking responsibility and ownership of situations and experiences is, in itself, a holistic, anchoring and awareness-enhancing behavior. With it comes an increased ability for clients to push the boundaries that are stifling their self-expression, identify immediate needs and engage in self-mobilization, creative experimentation, somatic expression and self-regulation, all of which are at the heart of an existence that has made peace with its past and is grounded in the present. As clients' awareness is ignited on a holistic level, they are empowered to decide whether their patterned behaviors still serve a purpose and how those behaviors can be modified to meet present needs.

How we inhabit our bodies reflects our way of being in the world. Through our bodies, we sense and experience, receive and perceive. Exploring the physical body and its manifestations of past sexual trauma helps clients integrate the physical, emotional and cognitive dimensions of their experience. Sensory-kinesthetic exploration brings history to life in the present and anchors it here, where it is more accessible.

Conscious engagement with the body's innate knowledge permits clients to access their own strengths in the process of healing. How empowering and transforming for our clients who have suffered from sexual trauma to recognize that their well-being exists within their own bodies — the very site of their original wounding. ❖

Knowledge Share articles are developed from sessions presented at American Counseling Association conferences.

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Member Insights – By Alicia Muñoz

Helping female clients reclaim sexual desire

Fostering the safety and trust necessary to explore clients' desire issues can move issues of female sexuality from an implicit undercurrent in counselors' work to an explicit focus of therapy



If you see women in your counseling practice, it will be hard to ignore the issue of female sexual desire in your work together, even if the focus of treatment is something that appears unrelated to sexuality. In fact, a woman's relationship with her own experience of sexual desire is often inextricably linked to her sense of identity, self-esteem, personal agency, energy levels, self-care habits and interpersonal relationships. Her desire issues and how she feels about them will weave their way, often implicitly, into your sessions.

The more that counselors can increase their awareness of the nuanced issues related to female sexual desire, the easier it will be to create a space in which clients can explore these issues safely and productively. Working with women more explicitly on understanding, experiencing and sustaining sexual desire can empower them to proactively regulate their moods, reduce stress levels and decrease symptoms of anxiety and depression. Furthermore, reconnecting with the motivation to feel sexual desire has the potential to help transition trauma survivors from "survival to revival" (in the words of couples therapist Esther Perel) as they access the enlivening energy of their own erotic life force.

In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, female sexual interest/arousal disorder is characterized by a lack of sexual interest or sexual arousal for at least six months. Whether a woman is upset or distressed by her lack of interest or arousal is a crucial criterion for the diagnosis. The disturbance can be moderate, mild or severe, lifelong or acquired, generalized or situational. Furthermore, according to the *DSM-5*, "Women in relationships of longer duration are more likely to report engaging in sex despite no obvious feelings of sexual desire at the outset of a sexual encounter compared with women in shorter-duration relationships."

Rosemary Basson, director of the University of British Columbia's sexual medicine program, has noted that other than in the early stages of a new relationship, women's arousal doesn't always follow the traditional model of spontaneous sexual desire. Rather, women's desire tends to be more responsive, with a deliberate choice to experience sexual stimulation required before an actual experience of arousal.

Estimates on how many women suffer from female sexual interest/arousal disorder vary widely, in part

because there is so much complexity, variability and subjectivity to how sexual desire issues and arousal problems are measured and experienced. According to an article by Sharon J. Parish and Steven R. Hahn in the April 2016 issue of *Sexual Medicine Reviews*, issues with sexual desire or arousal are present in 8.9 percent of women ages 18 to 44, 12.3 percent of women ages 45 to 64 and 7.4 percent of women 65 and older. These percentages translate into a significant portion of the female population. It is hard not to wonder what sociocultural circumstances are contributing to making problems with desire so pervasive and systemic for women.

In Standard E.5.c. of the 2014 *ACA Code of Ethics*, counselors are reminded to "recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and strive to become aware of and address such biases in themselves or others." This ethical consideration comes into play when counselors treat women with desire issues.

With the work of Helen Singer Kaplan's triphasic sexual response cycle and an ever-expanding body of nuanced research on women's sexuality, studies have come a long way from the male-centric, Freudian view of women's sexual and psychological functioning and even from Masters and Johnson's linear model of spontaneous sexual response. Researchers today strive to be more objective and aware of the physiological and psychological reality of women.

Even so, systemic prejudices related to gender and gender identity continue to saturate every area of girls' and women's lives, creating unique challenges in female clients in the areas of desire and sex. Fostering the safety and trust necessary to explore your clients' desire issues can move issues of female sexuality and desire from an implicit undercurrent in your work to an explicit focus of therapy. This can help clients separate the wheat of their

erotic potential from the chaff of limiting, destructive or shame-based gender and sexual conditioning.

Take Louisa, a 30-year-old client who has been married for two years. (Note: Louisa isn't an actual client; however, her situation illustrates common sexual desire issues experienced by clients who seek counseling.) Although Louisa initially seeks treatment for depression and anxiety, a few sessions into treatment she begins referring in passing to life stressors that are "TMI" (too much information). Following these TMI comments, Louisa deflects the conversation to other topics with a shrug and a laugh.

Counselors can be attuned to these "throwaway" comments and to dismissive humor, gently inviting clients to elaborate by expressing interest in the information the client is editing out. When the counselor gently points out Louisa's "TMI" reference and explores what she thinks might be too much information for the therapist, the issue of Louisa's sex life begins to surface. Counselors may need to reassure clients who experience shame around sexual desire and sexuality that it can be of great benefit to focus on and explore heretofore off-limit topics and the memories, beliefs, thoughts and feelings connected to those topics.

Interventions

The following interventions may provide springboards for exploring desire issues in counseling sessions with female clients.

1) Provide psychoeducation on the connection between relaxation and sexual arousal, and work with your client to identify ways she can relax. Maureen Ryan, a sexual health coach in Amherst, New York, says, "The first step to a great sexual experience is to relax. Pleasurable touch helps facilitate this process. The body becomes aroused, and then the desire follows. For most women, sexual intimacy precedes desire."

Explore the thoughts, fears and behavioral patterns that inhibit relaxation. Work on helping your client identify how she might create an external environment that would facilitate her transition into a sexually receptive or erotically engaged state. This might include activities that allow her to feel present or "in the flow" or connect more with pleasurable sensory input (tastes,

sounds, smells, visual stimuli, touch).

2) Invite your client to create a body map. Sex therapist Aline Zoldbrod suggests using this technique with couples to facilitate a dialogue about current preferences. However, it can also be used one-on-one with female clients who may struggle with shame issues related to their bodies and their experiences of sexual desire.

Your client draws a body shape, back and front, and then uses red, yellow and green crayons to color the shapes in. Green means "I like to be touched here always," yellow means "I like to be touched here sometimes," and red means "I never like to be touched here." This map can serve as one starting point for a deeper exploration of a client's relationship to her body and her history with touch.

3) Introduce the "prop" of a velvet vulva into your arsenal of psychoeducational tools and use it to help clients understand the anatomy of the vulva, the clitoris and what movements and sensations typically stimulate arousal. This prop can also be used to instruct women on arousal as counselors model a clear, sex-positive language for expressing needs and preferences to a partner.

4) Introduce your client to the concept of "sexual blueprints." You may want to provide a client with a handout summarizing sexologist Jaiya's five erotic blueprints: energetic, sensual, sexual, kinky and shapeshifter. Reading about and discussing these blueprints can reduce shame, normalize a client's experience of her own sexual predilections and help her consider new possibilities. Jaiya's website (missjaiya.com) has a quiz to help women and men identify their blueprints.

5) Explore the meaning of pleasure for your client. What turns her on? What charges her up and connects her to her own sense of flow or aliveness? A counselor can coach a client to say, "I feed my own desire when ..." and then complete the sentence with different activities, thoughts and behaviors that enliven her. Encourage your client to begin developing a running list of whatever it is she can proactively do to power herself up, delight herself and revitalize herself.

Also be sure to have an extensive list of your own desire-feeding activities. This will help you menu ideas for your clients.

6) Help clients develop awareness about the sex-negative and body-negative influences that have shaped how they see

and experience themselves and their bodies. Encourage them to limit the sex- and body-negative influences in their lives. This may mean avoiding certain magazines, being mindful about television shows and choosing not to watch certain movies or videos. It may mean setting clearer boundaries with select people in their lives.

Also help clients explore ways that they can take in more sex- and body-positive messages, either through reading different magazines, limiting their exposure to narrow standards of beauty, increasing their vigilance of the kinds of advertising or body imagery they expose themselves to, or regularly and intentionally appreciating their own bodies through pleasurable body rituals and experiences.

A shift in attitude

Over time, Louisa begins to understand that the lack of sex in her marriage underlies her anxiety and depressive symptoms. She fears it means that she and her husband are on their way to divorce and that it's "all her fault." Here, the counselor helps Louisa increase her awareness of this critical inner voice and develop greater self-compassion.

Louisa's husband has become more vocal about their sexual problems and grown increasingly more irritable and withdrawn in their day-to-day life. As a result, Louisa is no longer able to continue pretending the problem is just situational, temporary or unimportant.

In therapy, she examines her sexual misconceptions and beliefs and the influence of her family's cultural and gender-based expectations of her. To her surprise, she realizes she has limited awareness of her actual bodily sensations. She often "lives in her head" and ignores the signals her body sends her. As a result, she has never really tuned in to what she feels leading up to a sexual encounter. Her low sexual desire is just the tip of an iceberg of denial related to sensations and emotions.

Part of Louisa's work in therapy becomes learning how to "listen" to her body. She practices doing this in session and also sets aside time outside of sessions to sit quietly and observe her own sensory experience.

In the past, when Louisa lost her motivation to have sex with one of her boyfriends and couldn't recreate the feeling of strong, active arousal with him, she would interpret it as "falling out of love"

or the boyfriend “not being right for her.” It wasn’t until Louisa married her husband that she was faced with the stark truth of her own sexual experience: She had a hard time experiencing spontaneous, robust arousal once the novelty of a relationship wore off. Mostly, later in a relationship, she simply responded to her partner’s desire for her.

This insight signaled a shift in Louisa’s attitude toward sex and herself. She started to mourn her lack of erotic engagement with her past partners and current husband and to commit to cultivating a relationship with her own erotic experience. She began recognizing her own inhibitions, her lack of erotic accountability and the expectation she had always carried that her partner should know what pleased her without her assistance, guidance or willingness to explore the ways that their needs and desires met or diverged.

Because Louisa loved her partner and wanted to make their marriage work, she committed to learning *how* to experience her own desire and arousal more regularly. Her motivation to feel desire for her own pleasure and sense of wholeness shifted her approach to the sexual disconnection in

her marriage from that of a burdensome problem to an adventure.

Untapped potential

When it comes to working effectively with female sexuality and desire, remaining neutral about larger cultural biases can stall your work as a counselor. In a culture saturated with narrow and distorted models and templates of beauty, it is nearly impossible for human beings who emerge from their mothers as female babies to grow up free of misconceptions about their core selves, their bodies, their sensuality and their eroticism.

Some women may manage to stay intuitively connected to their erotic core throughout childhood and adolescence despite the social, relational and societal risks involved, perhaps even making it into adulthood relishing the full range of their sexual experiences on their own terms. A great number of women, however, wouldn’t have survived physically, much less psychically, without shutting off their sexual circuit boards.

Usually, this shutdown isn’t a conscious choice. It is something that girls learn to do within the context of their relationships as

a way of maintaining caregivers’ and others’ love and approval. Even for girls growing up in progressive, supportive families, fitting in with peer groups or feeling socially rooted can sometimes cost them some important piece of connection to their core sexual selves. Girls may grow up lacking erotically vibrant, powerful female role models. Sometimes their families and circumstances don’t allow them the luxury of maintaining a strong, healthy, intact relationship with their bodies.

When girls suppress aspects of their deepest erotic impulses and experiences, layers of judgment and shame encase not only what and how they feel, but also who they are. Like a seed trapped in amber, a woman’s erotic potential can remain untapped even as she develops and grows in other areas. It waits for the right conditions to emerge.

Counselors can provide those conditions in therapy. Here are some key ways that counselors can help women reclaim their erotic selves.

- 1) Take continuing education courses on sexuality.
- 2) Read progressive, inclusive books on women’s sexuality and women’s sexual

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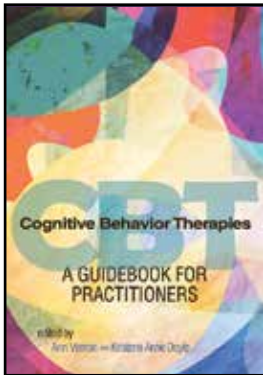
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empowerment, such as *Getting the Sex You Want* by Tammy Nelson, *She Comes First* by Ian Kerner, *Mating in Captivity* by Esther Perel, *Woman on Fire* by Amy Jo Goddard, *Pussy: A Reclamation* by Regena Thomashauer, *Come as You Are* by Emily Nagoski and *Women’s Anatomy of Arousal* by Sheri Winston.

3) Familiarize yourself with the facts regarding the unique challenges that women continue to face today locally, nationally and globally, particularly as they relate to physical safety, fiscal equality, political representation and reproductive issues and rights.

4) Learn to talk about all of the parts of women’s bodies with ease. Practice with your children, spouses, colleagues and friends. Learn the exact locations of women’s body parts, study how they interact and learn to identify a woman’s body parts by their correct names (e.g., distinguishing between a woman’s visible genitals — her vulva — and the internal, muscular tube that leads from her vaginal opening to her cervix — her vagina). Learn to discuss sex, sexuality and sexual acts correctly and comfortably.

5) When you pick up on a client’s reactivity, defensiveness, shame or self-consciousness related to a sexual topic, bring warmth and compassion to the moment through attuned interventions. For example: “I noticed that you covered your eyes just now as you mentioned having sex with your boyfriend. Can we be curious about what just came up for you?”

It is important to keep in mind that low desire and lack of sexual interest are issues that many women won’t openly admit to, even when these experiences are their daily reality. There is a lot at stake. Just as a man’s sexual identity and sense of competence can get tied up with his ability to pleasure his partner to orgasm or to maintain an erection, a woman’s sense of sexual self-worth can be intricately connected with her ability to both stimulate and quench her partner’s sexual desire.

When the impetus or the drive to engage in sex with her partner or spouse wanes, a woman’s sense of sexual self-confidence can waver. It can feel as if she is failing at an essential aspect of her being: loving and being loved sexually. It can also inspire terror. Will she lose connection to this person she depends on and loves? How will this affect her family relationships? Is this a prelude to something worse? What changes

lie around the corner as a result of her inability to match her partner's sexual needs with her own authentic responses and initiatives?

Counselors are in a privileged and important position with their female clients at this particular historical juncture. Women are feeling pulled to take up leadership positions and exert influence in spheres of power previously dominated by men, from political offices to corporate headquarters to influencing the ecological trajectory of the planet. To experience the fullness of their emotional range, the force of their uniquely feminine values, priorities and principles, and the vitality of their full aliveness, many women need help developing a healthier relationship with their erotic selves. Because many women have adapted and suppressed aspects of themselves to function in a world that prioritizes the more traditionally masculine values of strength, dominance, competition and self-protection, they need to find ways to access the more traditionally feminine priorities of sustainability, vulnerability, connection and empathy to feel truly like themselves again.

Counselors can safely, warmly and sincerely support the exploration of women's low sexual desire or inhibited arousal by first prioritizing a woman's desire as an essential energy source in her life. They can help their female clients navigate the unique, nuanced challenges of low desire and the ways it manifests in a woman's relationship to her own self, her body and those she loves. Once this issue is prioritized in treatment, it can be made explicit and explored. From there, it becomes easier to disentangle the negative beliefs that women harbor about their bodies and themselves from their inalienable, noncontingent worth as women.

Because many women have come to experience their own desire as beyond their control, they may fear that *they* are the problem — outliers on the graph of normative human sexual desire doomed to disappoint and frustrate the people they love and need most. Helping women take control of their own experience of sexual desire through explicit counseling interventions has the potential to shift clients' views of what's possible for them erotically and, in so doing, what's possible

for them as vibrant, entitled human beings with desires that matter. This shift is seismic and can transform all aspects of women's lives. ♦

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Member Insights – By Carl Sheperis & Franzi Walsh

The fragility of freedom

Examine the barriers that ex-offenders confront when trying to transition back into society, and the critical role that counselors can play in addressing recidivism becomes obvious





With more than 2.2 million Americans behind bars, there are more citizens incarcerated in the United States than in any other country in the world, according to the U.S. Bureau of Justice Statistics. The United States can also lay claim to the highest rate of recidivism. According to a Department of Justice study, a staggering 76.6 percent of released inmates are rearrested within five years. A lack of basic literacy skills and job training is part of the issue, but it is equally important that we begin to understand how imprisonment behaviorally and psychologically conditions individuals to perpetuate the cycle. It is a problem that is forcing lawmakers, think tanks and the public at large to rethink our nation's current approach to incarceration and rehabilitation.

As educators in the social sciences and criminal justice, we recognize that education and vocational job training are crucial first steps to addressing rates of recidivism. A study by Rand Corporation, a nonprofit research organization, found that inmates who participated in correctional education programs were 43 percent less likely to return to prison than were those who did not participate. Furthermore, those same individuals were 28 percent more likely to find employment upon release. These findings clearly suggest that those who are more prepared to tackle the challenges associated with the world post-prison are less likely to resort to criminal actions to achieve basic means.

However, when we talk about recidivism, there are issues and solutions that lie far beneath the surface, often entrenched deep within the psyche of former inmates. Simply put, we cannot overlook the psychological and sociological effects of imprisonment, including the barriers to achievement that they cause. From a mental health perspective, it is important to recognize that individuals who are transitioning from incarceration require support to be successful once they leave the prison system.

Many individuals involved in the criminal justice system have multiple mental health and substance abuse

issues. In fact, the National Comorbidity Survey Replication demonstrated that strong relationships exist among mental health, substance abuse and history of incarceration. Based on research conducted by Jason Schnittker, Michael Massoglia and Christopher Uggen in 2012, the majority of common disorders documented among former inmates could be traced back to childhood, before involvement in the criminal justice system. Their research showed that mood disorders, substance abuse and impulse control disorders had strong relationships with various patterns of involvement in the justice system.

In 2014, research by Amy Blank Wilson, Jeffrey Draine, Stacey Barringer, Trevor Hadley and Arthur Evans found that those individuals with comorbid mental health disorders had a 40 percent higher rate of recidivism in comparison with other offenders. In their study, more than 50 percent of the sample had at least one documented readmission to incarceration within three years. Clearly, problems with mental health act as a barrier to successful transition to the community for ex-offenders, and there is a need to develop more comprehensive support services for these individuals.

Incarceration also leaves little room for asserting personal responsibility, with basic functions such as eating, bathing,



exercising and socializing largely outside of inmates' control. Rigid programming has such a strong psychological effect on inmates that, once they are released, individual freedom often feels foreign or overwhelming. When combined with the additional stress of managing symptoms of mental health, the transition process becomes even more problematic.

Schnittker, Massoglia and Uggen demonstrated that there is a significantly higher relationship between mood disorders and subsequent disability after incarceration than what exists among the general U.S. population. This means that when offenders with mental health issues are released from the criminal justice system and left to create their own paths, it is likely that they will have extreme difficulty making successful transitions.

Counselors and support personnel can help break the cycle

Because mental health has been shown to have prominent comorbidity with incarceration, and because recidivism can be predicted for those with mental health issues, counselors who take an active role in addressing the needs of these individuals as they transition back to the community have the opportunity to make a significant impact. That impact extends beyond the ex-offender to the individual's family, community and generations to come.

To create real change in the criminal justice system, all offenders — regardless of their history of mental health or substance use issues — need additional support to break a cycle that perpetuates

their involvement. Offenders are considered a vulnerable population and should receive support in a manner that is commensurate with other vulnerable populations. Successfully addressing the complex needs of offenders requires a wraparound approach that is multidisciplinary and multifaceted, and counseling is an important element in the spectrum of needed services. Professional counselors experienced in addressing the unique needs of individuals who have been incarcerated can help to break down psychological barriers to achievement through the use of cognitive restructuring, motivational interviewing and other evidence-based approaches. Specifically, counselors can help relieve the stagnation in which many prisoners find themselves trapped. This can be done in part by offering education about appropriate decision-making and general life skills.

Counseling is certainly an important facet of reintegration, but we believe that an array of social and human services support personnel must be in place to help make this process successful. Probation and parole officers monitor the transition process, but there should also be individuals who can provide support for the social, emotional, medical, educational, occupational and recreational needs of those transitioning from incarceration back into the greater community. This multidisciplinary group of professionals must work together to create change for the individual and for the overall system. They must provide effective treatment and serve to advocate for change.

Advocacy and change can begin with small steps. Through past experiences, we have found that labeling someone a criminal can become too easily generalized. We often think of a prisoner as a lawbreaker first, rather than as an individual who has broken a law. The key difference is the articulation of the individual, which encompasses an entire life that led to the moment a crime was committed — and, similarly, extends to the quality and achievement of life upon release. As a society, we have moved toward person-first language for special populations. It is now time to include offenders in the category of special populations and to drive change through the ways in which we talk about offenders.

Addressing the shortage of mental health professionals

Although the need is strong for counseling and human service support for ex-offenders, the fact is that a shortage exists of personnel available to provide these services. According to the U.S. Health Resources and Services Administration, there are nearly 4,500 shortage areas for mental health services throughout the United States, and there is no identified time frame for these shortage designations to be removed.

The shortage of trained professionals is daunting, and it becomes even more problematic when examining the need for specialized providers such as those who have experience addressing the needs of offenders. As educators, we believe one of the crucial elements of our role is to

prepare students to meet the needs of our communities. We also believe that we must educate students to consider perspectives that challenge stigmas and help promote positive change.

Because there is such a shortage of counselors who specialize in working with offenders, the process of filling this gap must begin in the educational realm. Addressing the workforce gap can also be done through the development of bachelor's-level programs in psychology, social work and human services that have specific tracks dedicated to the support of the offender population. In addition to helping meet a population need, programs of this nature would serve as natural bridges for undergraduates to pursue graduate degrees in counseling or similar helping professions.

Counselor educators can change the conversation

One way to change the conversation is through formal education. Standard F.7.c. of the *ACA Code of Ethics* requires counselor educators to take an active role in educating students about diversity. Because offenders are considered a

Those experiences directly following imprisonment often have the greatest impact on an individual's success in transitioning back into the community.

vulnerable population, it is important for counselor educators to include this population as part of the knowledge base for counselors-in-training. Counselor educators can also make concerted efforts to develop field placement relationships with the criminal justice system and community agencies that serve offenders.

Changes to the way that we serve the offender population ultimately will be driven by the strength of voices among

practicing counselors and other helping professionals. As stated in Standard A.7.a. of the *ACA Code of Ethics*, "When appropriate, counselors advocate at individual, group, institutional and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients." It is an ethical imperative for counselors who work with offenders to engage in individualized efforts to advocate for the elements needed to help their clients make successful transitions. Each individual effort is important and creates momentum toward greater social change.

Although we take small individualized steps toward a new process, we also must keep our eyes on greater systemic change. Rehabilitation is a matter of systems, encompassing the criminal justice system, the parole system, the mental health system, the human services support system, the employment sector and the broader community. Those experiences directly following imprisonment often have the greatest impact on an individual's success in transitioning back into the community. We can begin tackling this issue seriously if we

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combine training and education with a renewed focus on the psychology of both imprisonment and freedom, working as one to promote transformation even for those individuals for whom we might have thought it impossible.

Summary recommendations

Social change is a process that unfolds over time, but it begins with recognition of a disparity. This leads to grassroots efforts to develop a movement that will create sustainable change. At the University of Phoenix, we have taken a step toward addressing these issues by creating a bachelor's degree in correctional program support services to train individuals to help offenders be successful during and after transitioning back into the community. We have also worked to collaborate across our colleges of social sciences and criminal justice to develop multiple projects that address the broad needs of offenders. These small efforts are just one step in creating broader change. We invite readers to join the effort and to develop their own small steps.

Here are some suggestions for beginning the advocacy and change process:

- ❖ Become an informed counselor by exploring the research on mental health, substance abuse and incarceration.
- ❖ Examine the organizations in your community that serve the offender population, and develop a relationship with providers in that network.
- ❖ Look for opportunities to advocate for system change at the local, state and national levels. Contact your state counseling association or the American Counseling Association to determine any ongoing initiatives that you can support.

- ❖ Obtain additional training in evidence-based practices that have been effective with the offender population.
- ❖ Counselor education programs can consider developing specialty courses or specialized field experiences related to the offender population.
- ❖ Counselor educators can develop cross-disciplinary relationships that help to promote greater understanding of the needs of offenders transitioning back into the community.
- ❖ Counselors can develop relationships with legislators and local officials.
- ❖ Join organizations such as the International Association of Addictions and Offender Counselors, a division of ACA.
- ❖ Join a professional network of colleagues who have an interest in serving the offender population.
- ❖ Look for opportunities to educate and encourage the conversation about system change in your home community. Raising awareness is one key to successful change.

Conclusion

The research and literature have clearly demonstrated that:

- ❖ Offenders are a vulnerable population
- ❖ Many offenders have mental health and substance abuse disorders
- ❖ Those offenders with comorbid mental health issues have a 40 percent higher rate of recidivism than other offenders
- ❖ Offenders — regardless of mental health history — face incredible barriers in their transition back into society

Our hope is that as a result of reading this article, more counselors will feel empowered to address these issues and

advocate on behalf of this vulnerable population. We encourage counselors to take a stand to address the existing barriers that block offenders from successful reentry into our communities, and we look forward to using our collective knowledge and training to impact future generations. ❖

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ct@counseling.org

Counseling Today reviews unsolicited articles written by American Counseling Association members. To access writing guidelines and tips for having an article accepted for publication, go to ct.counseling.org/feedback.

CEO's Message

Continued from page 7

times. Some people may never have felt previously that the government or other societal issues truly affected them, but that may have changed over the past 12 months. For ACA to better serve you, we want to know what else we can provide that would enhance the work you do.

Despite the many changes going

on, you can count on one thing: my ongoing respect and admiration for everything that professional counselors and counselor educators do for so many millions of clients and students each and every day. Your work is critical, and those of us on staff hope you know how much we want to provide information,

resources and support for what you do.

As always, I look forward to receiving your comments, questions and thoughts. Feel free to contact me by phone at 800-347-6647 ext. 231 or via email at ryep@counseling.org. You can also follow me on Twitter: [@Richyep](https://twitter.com/Richyep).

Be well. ❖

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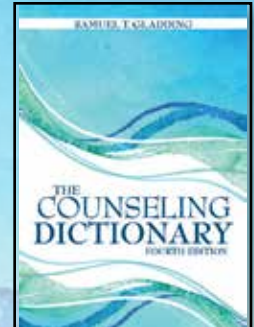


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COMING EVENTS

FCA Annual Convention

Oct. 13-14

Orlando, Florida

The Florida Counseling Association's 68th Annual Convention, with the theme "Counselors Lighting the Future: Through Learning, Leadership and Legacy," will be held at the Florida Hotel and Conference Center. FCA is proud to present Mawi Asgedom, author of the memoir *Of Beetles and Angels: A Boy's Remarkable Journey From a Refugee Camp to Harvard*, as its keynote speaker. Each convention participant will receive a copy of his book with registration. Mawi has been featured on *The Oprah Winfrey Show* and is recognized for his motivational speeches. Our plenary speaker will be ACA President Gerald Lawson. A Red Cross disaster mental health training series will be offered Oct. 12 as a pre-convention event. CE hours will be offered. For more information and to register, visit flacounseling.org.

WCA Annual Conference

Oct. 12-14

Cody, Wyoming

The Wyoming Counseling Association will hold its annual conference at the Cody Holiday Inn. The theme is "Supporting Diversity: Empowering Emerging Leaders." This year's keynote speakers are Marlise Lonn, who will speak on how enhancing diversity, incorporating advocacy and strengthening voices from a variety of cultures and contexts serve to advance the profession, and David Kaplan, chief professional officer of the American Counseling Association, who will present on "Deep Dive Ethics." Visit our website at wyomingcounselingassociation.com for registration and sponsorship opportunities.

Imagery International Annual Imagery Conference

Oct. 20-22

Menlo Park, California

This year's conference theme, "Enlivening the Mind-Body-Imagery

Connection," focuses on the curiosity surrounding the wisdom that lives within our bodies as we journey into the imagery, mystery and vitality of the mind-body-imagery connection. We will explore: What is mind-body-imagery awareness? How do the images that reside within influence our bodies? What is important in learning more about the mind-body-imagery connection? Joining us will be leaders in the mind-body connection field presenting on these topics: accessing your cellular wisdom, resetting the brain's default mode, body image, body imagery, body mapping; revealing the images within, elevating healing through color consciousness, and tapping into creativity to enhance creativity in art and life. Register at imageryinternational.org.

KCA Annual Conference

Nov. 1-3

Louisville, Kentucky

The Kentucky Counseling Association 60th Annual Conference will be held at the Crowne Plaza Airport Hotel. The celebratory theme is "Advocacy, Treatment and Collaboration: 60 Years of Counseling Excellence." Christian Moore, Sam Gladding and Sadiqa N. Reynolds will be our keynote speakers. A variety of pre-conference workshops are scheduled for Nov. 1. Registration includes NBCC hours, an opening reception, school counselor and LPCC/LPCA luncheons, social events and a closing awards buffet brunch. For more details and registration information, visit the website at kyca.org.

TCA Annual Professional Growth Conference

Nov. 15-18

Galveston, Texas

With more than 160 CE programs, 50-plus exhibitors and in excess of 2,000 counseling professionals in attendance, the Texas Counseling Association's 61st Annual Professional Growth Conference and Annual Meeting will educate, enlighten and enhance your professional skills. Make valuable connections with other professionals, spend some time

walking on the beach and take the chance to recharge your batteries. The San Luis Resort Spa and Conference Center is the perfect place to explore this year's theme, "Counselors Choosing Courage." Take time out of your busy schedule to make new connections, gain valuable insights into the latest trends and research, and enjoy Galveston Island. For more information, visit txca.org.

ASGW National Conference

Feb. 1-3

Savannah, Georgia

The Association for Specialists in Group Work cordially invites you to join us at the ASGW Conference. Escape the cold, wintry weather and wrap yourself in a blanket of positivity focused on our conference theme — "Groups Nurturing Positivity for Greater Good" — as well as on other topics. Enjoy Savannah's Historic District at the newly renovated DeSoto Hotel, with affordable room rates of \$149 per night. Learn from our outstanding keynote speakers, Sam Gladding (Feb. 2) and Carolyn Stone (Feb. 3), and attend a range of dynamic sessions. CEUs are available. Register early for the best rates at asgw.org/asgw-store/asgw-conference-registration. See you in Savannah!

TSCA Annual Professional School Counselor Conference

Feb. 18-20

Galveston, Texas

Join the Texas School Counselor Association at Moody Gardens for Texas' largest gathering of professional school counselors as we learn, network and recharge. Enjoy more than 70 CE programs, networking events and 40-plus exhibitors that will take your professional skills to the next level. Take time out of your hectic schedule and enjoy the beautiful Moody Gardens rainforest, aquarium, museum and so much more. This conference is co-sponsored by the Texas Counseling Association. For more information, visit txca.org.

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The *Journal of Counseling & Development* (JCD) is now available in an app. Take advantage of this FREE ACA member benefit, which includes:

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FYI

Call for journal manuscripts

The *Journal of LGBT Issues in Counseling* is accepting manuscripts

for consideration for publication. The journal publishes manuscripts that report cutting-edge research, best practices, and emerging trends and issues focused on counseling LGBTQ+ communities at all developmental stages of life. Manuscripts represent one of the following categories: empirical research, innovative practices or theoretical articles. Manuscripts should be of interest to clinical mental health and school counselors, counselor educators and other helping professionals working in diverse settings, including schools, mental health agencies, family service agencies, universities, addiction and offender treatment settings, and sexual health centers. For detailed submission guidelines or further questions, visit the journal's webpage at Taylor & Francis Online, tandfonline.com/toc/wlco20/current, or contact editor Michael Chaney at chaney@oakland.edu.

Call for journal submissions

The *Wisconsin Counseling Journal (WCJ)* is seeking articles for possible publication in the Spring 2018 edition. The journal places emphasis on original, data-based research but will consider

conceptual articles (e.g., position papers, case studies). All manuscripts submitted are subject to a peer-review process involving members of the editorial board. *WCJ* is focused on topics of interest to counselors, including the following four areas: innovative methods, theory and research, professional development, and current issues affecting counselors and the counseling profession. For submission guidelines, contact editor Melissa Kraemer Smothers at kraemerm@mtmary.edu. For additional information about the journal, visit wisconsin-counseling-association.com. The deadline for submissions is Oct. 15. ♦

Upcoming deadlines for Bulletin Board submissions

- ♦ December issue: Nov. 1
- ♦ January issue: Nov. 30

Send Bulletin Board announcements of 125 words or less to Jonathan Rollins at jrollins@counseling.org.



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Nominate yourself or another ACA member for an ACA Committee.

ACA President-elect Simone Lambert is seeking nominations for American Counseling Association committee appointments. She will be appointing professional members for each committee who will serve three-year terms, as well as a student representative for each committee who will serve a one-year term.

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Nominations are due December 1, 2017 at 11:59 pm ET.

Learn more and review nomination instructions at counseling.org/committee-call



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