Counseling Today

An American Counseling Association Publication ct.counseling.org September 2020 • Volume 63/Number 3

Climate change and mental health

Confronting the symptoms of compassion fatigue

Revisiting 20/20: A Vision for the Future of Counseling

Challenging racism in the counseling profession

Understanding and addressing client confabulation

One is one too many

When they need your help the most, be ready with a tool you can trust

When you have a client who has reached their limit, you need to act quickly. The **Adult Suicidal Ideation Questionnaire (ASIQ)** is a brief intake form that helps ascertain whether a client is thinking about suicide.

Because the sooner you know, the sooner you can help get them on the road to recovery.

At PAR, we develop targeted tools designed to meet your client's needs—and yours.

ACA members:

use Promo Code **9WE** for **10% off** your order of $200 or more.

Offer expires Jan. 1, 2021. Cannot be combined with any other promotion, discount, coupon, or special offer or applied to previously placed orders.

ASIQ Adult Suicidal Ideation Questionnaire

Learn more at parinc.com/ASIQ

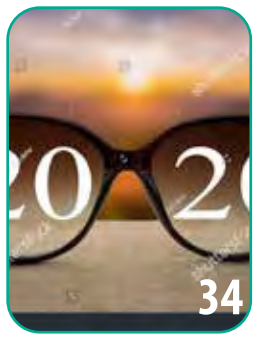
PAR • 1.800.331.8378 • parinc.com

Counseling Today

September 2020

Cover Story

Features



Need to Know

Check out these recent exclusives at CT Online

- Making the "new" normal: Five tips for providing teletherapy
- A climbable mountain: Quitting smoking and managing mental health
- *Primum cura te ipsum*: First, heal thyself
- The revised meaning of self-care in the wake of COVID-19

Visit *ct.counseling.org* for these articles and many other online exclusives

American Counseling Association
counseling.org

Display pride in your profession!

The Varsity

Ready-to-frame

You are a member of the American Counseling Association, the largest and most respected professional counseling organization in the world. You've worked hard for your credentials and now ACA is pleased to offer this beautiful framed certificate for your office or home.

The Varsity

- Created exclusively for the current American Counseling Association members adhering to the highest ethical values.
- Showcases your name with pride on a pearl-bordered white certificate framed in durable satin, gold-tone metal.
- A high quality black matboard preserves your document.

Also Available

- Ready-to-frame certificate only. Your name showcased with pride on a pearl-bordered white certificate.

TO ORDER

Phone 800-298-2276 (M–F 8:30 am–5:30 pm, ET)
Web *counseling.org/membership-certificates*
Mail ACA Membership Certificates
6101 Stevenson Avenue, Suite 600, Alexandria, VA 22304

Qty	Frame Selections	Price	Amount
	The Varsity (fits 8.5 x 11 certificate)	$85.00	
	Ready-to-frame Certificate (free shipping)	$17.00	
NOTE: *Please allow 2–4 weeks for delivery*	Shipping Cost – U.S. $9.00		
	Shipping Cost – International $30.00		
	VA residents add 6% sales tax		
	TOTAL		

Payment Method

(fill out if paying by check or money order)

Total amount enclosed $ _____
Make check or money order, payable to the American Counseling Association in U.S. funds.

Credit Card Payments
To order by using a debit/credit card, please log on to *counseling.org/membership-certificates* to pay online, or contact your ACA Engagement Specialist at 800-298-2276, M–F 8:30 am–5:30 pm, ET.

Shipping address

If this is a business address, please check here [ ]

Name _____ Member No. _____
Address _____
City _____ St. _____ Zip _____
Country _____ Phone _____
Email _____

NAME ON THE CERTIFICATE

Please print your **full name only** *exactly* how you want it to appear on the certificate. *Maximum 25 characters, including space and punctuation.*

Sue Pressman | From the President

Live your dream

"Everybody has a calling. And your real job in life is to figure out as soon as possible what that is, who you were meant to be, and to begin to honor that in the best way possible for yourself." — Oprah Winfrey

As a counseling professional, have you ever thought about starting your own business?

When I decided to launch my business, many years of experience — in education, career counseling, teaching and training, in university, government and corporate settings — helped me prioritize choices and make decisions. I developed *transferable skills* such as how to read a request for proposal, write a proposal, review and understand a contract/task agreement, build business relationships and negotiate. Those transferrable skills became the *drivers* that turned into actions and set my business in motion. My business grew from a counseling practice to include training, curriculum design and organizational studies using quantitative and qualitative research methodologies.

Today, the impact of COVID-19 is affecting how we work and how we will conduct business in the future. The age of digitization has changed the means by which we provide services. Providing these services requires creativity, determination, planning, the development of new skills and the use of different technologies (e.g., search engine optimization, online learning, accessible and purposeful websites). In other words, *the new normal*.

Get started and grow into the future. Balancing your needs and requirements is different for everyone. When I decided to launch my business, I kept a part-time job so that I could still depend on steady income. This created multiple income streams and provided me with the flexibility to volunteer, network and write proposals. The business grew and became sustainable.

Moving beyond the dream requires a plan and a structure. These will be your guiding lights. In the United States, there are several business structures and certifications available to you. Here are three: sole proprietorship, limited liability company (LLC) and incorporated business (Inc.). Your business goals and objectives will be your starting point to deciding which is right for you. If you are uncertain about what structure might work best for you, I strongly recommend consulting with a certified public accountant and your state's corporation commission.

Establish your brand. Branding provides an identity and becomes an integral part of your business capabilities statement. Know your niche! What distinguishes you?

When I see ACA's logo, I can easily identify the "C" — representing counseling — that is encompassed in the blue circle against the white background. This tells me a story without words.

Be consistent with all of your marketing materials. Your logo and graphics should be easily recognized on all of your communications and marketing materials (website, social media, brochures, emails and so on).

Continued on page 27

Counseling Today

Counseling Today Staff

Publisher
Richard Yep

Associate Publisher
Carolyn C. Baker

Editor-in-Chief
Jonathan Rollins
703-888-4416
jrollins@counseling.org

Senior Writer
Laurie Meyers
703-212-2247
lmeyers@counseling.org

Senior Writer & Social Media Coordinator
Bethany Bray
703-823-6702
bbray@counseling.org

Contributing Writer
Lindsey Phillips

Senior Graphic Designer
Carlos J. Soto II
703-823-9882
csoto@counseling.org

Advertising Representatives
Mark Mohanna
214-291-3657
Evelyn Reyes-Marquez
214-291-3656
adsales@counseling.org

CT Column Editors

Advocacy Update
Guila Todd & Dania Lofton

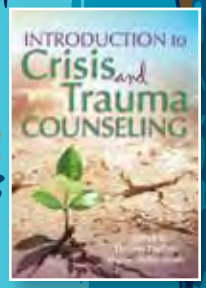
Counselor Career Stories
Danielle Irving-Johnson

Neurocounseling: Bridging Brain and Behavior
Lori Russell-Chapin & Thom Field

Private Practice Strategies
Deb Legge

Risk Management for Counselors
Anne Marie "Nancy" Wheeler

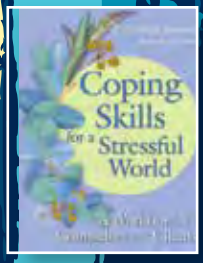
New Resources
for Disaster, Trauma, and Crisis Counseling



Introduction to Crisis and Trauma Counseling
edited by Thelma Duffey and Shane Haberstroh

Introduction to Crisis and Trauma Counseling integrates evidence-based models and best practices with relational-cultural theory, which is responsive to the many forms of traumatic stress and tragedies that clients experience. Readers will gain vital skills as they learn real-life approaches to crisis work with diverse populations in a variety of settings, including individuals, families, communities, students, military personnel, violence survivors, and clients who are suicidal.

2020 | 368 pgs | Order #78166 | ISBN 978-1-55620-377-0
List Price: $74.95 | **ACA Member Price: $54.95**



Coping Skills for a Stressful World: A Workbook for Counselors and Clients
Michelle Muratori and Robert Haynes

This comprehensive counseling tool kit for stress management provides clinicians with hundreds of client exercises and activities. Representing a variety of therapeutic approaches, this workbook offers creative techniques for helping clients handle traditional concerns, including anxiety, depression, anger, and grief in addition to heightened present-day issues, such as natural and human-made disasters, the misuse of social media, political divisiveness, social injustice, and mass shootings and other violence.

2020 | 224 pgs | Order #78163 | ISBN 978-1-55620-389-3
List Price: $62.95 | **ACA Member Price: $44.95**

Disaster Mental Health Counseling: A Guide to Preparing and Responding
Fourth Edition

edited by Jane M. Webber and J. Barry Mascari

This timely book provides current research and skill-building information on Disaster Mental Health Counseling for counselors, educators, students, and mental health responders in agencies, schools, universities, and private practice. Real-world responses to violence and tragedies among diverse populations are presented, and responders share their personal stories and vital lessons learned.

Published by the American Counseling Association Foundation

2018 | 400 pgs | Order #78126 | ISBN 978-1-55620-361-9
List Price: $64.95 | **ACA Member Price: $47.95**

Ordering Information

Order Online: https://imis.counseling.org/store/
By Phone: **800-298-2276** (M–F, 8:30 am – 5:30 pm ET)

Richard Yep | CEO's Message

A very different start to the school year

The traditional beginning of the school year looks quite different this month. Typically, concerns revolve around how K-12 students will "get back into the swing of things" after a summer spent vacationing, working part-time jobs or going to camp, but the coronavirus pandemic is providing an entirely new backdrop as students return to school.

While some kids may still hop on a bus, millions of others will be logging into their classrooms this month through their computers. Last year at this time, could anyone have imagined this happening? In the United States, the coronavirus pandemic has disrupted multiple aspects of people's lives. Some people may have built up immunity to the coronavirus, but no one is immune from the impact the virus has had on our social circles and communities.

The lack of clear leadership and consensus on how to battle the pandemic has resulted in conflict, aggression, bullying, anxiety and political games. While many acknowledge what science informs us to do to stem the spread of the virus, those with authority and in positions of power seem unable to understand that wisdom and guidance. Those who neglect to practice physical distancing, wear a mask or follow guidelines for proper hand-washing are putting both their own health and well-being at risk and the health and well-being of those trying to help them. This means that professional counselors, who are key providers of critical services, are put at risk. While it may be an individual's "right" to put themselves in harm's way, what if doing so places mental health professionals in danger? Frankly, that is not OK.

Many people in this country have different thoughts, perspectives and beliefs on myriad issues. However, the pandemic does not discriminate regarding who will be infected. Professional counselors already had challenging jobs, whether they were working in schools, private practice, community agencies, hospitals or the corporate sector. Always striving to find the best in others and working diligently to truly make others' lives better is hard enough, personally and professionally, without having to deal with the coronavirus pandemic.

Having to engage in telebehavioral health added yet another dimension (and challenge) to the amazing work to which counselors dedicate themselves. That is why, back in April, ACA provided a series of online education sessions to help counselors better understand exemplary telebehavioral health practices. We made those sessions available to all ACA members, as well as to nonmembers, at no cost. We felt it was one way that ACA could step up to help with what professional counselors were facing. I'm pleased to note that more than 20,000 counselors signed up for the sessions. I'm also happy to announce that we are making that offer available again, both to ACA members and nonmembers, starting this month and running through November.

So, while you do the important work of serving clients and students, we hope you will take advantage of the continuing education we are providing on telebehavioral health. I would also be very interested in hearing what else you might like to learn more about.

Continued on page 17

Counseling Today

American Counseling Association

President
Sue E. Pressman
800.347.6647
drsue@pressman-consulting.com

President-Elect
S. Kent Butler
800.347.6647
skbutler@ucf.edu

CEO
Richard Yep
800.347.6647 ext. 231
ryep@counseling.org

Counseling Today (ISSN 1078-8719) is the monthly magazine of the American Counseling Association, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22304-3300; Telephone: 703.823.9800; Internet: ct.counseling.org.

Subscriptions are available for $176 (individual rate) or $204 (institutional rate) for 12 issues.
Email: cs-journals@wiley.com
Americas: 1-800-835-6770
Europe, Middle East & Africa: +44 (0)1865 778315
Asia: +65 6511 8000
Single copies are available for $15 each by calling ACA in-house fulfillment at 800.298.2276.

Periodicals postage paid at Alexandria, Virginia, and additional mailing offices. Postmaster: Send address changes to ACA Member Services, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22304.

Editorial Policies

Counseling Today reviews unsolicited articles for publication that are written by ACA members. Not all articles will be accepted for publication. Review writing guidelines, publication tips and sample articles at ct.counseling.org/feedback/. Send submissions for review to ct@counseling.org.

Nondiscrimination Policy

There shall be no discrimination against any individual on the basis of ethnic group, race, religion, gender, sexual orientation, gender expression, gender identity, age or disability.

Mission Statement

The mission of the American Counseling Association is to promote the professional development of counselors; advocate for the profession; and ensure ethical, culturally inclusive practices that protect those using counseling services.

Advocacy Update

You asked, we answered (Part 2)

By Brian Banks, Dania Y. Lofton, Dominique Marsalek, Danielle Irving-Johnson & Guila Todd

In May, the American Counseling Association hosted its 2020 Government Affairs and Public Policy Virtual Town Hall to provide legislative updates and highlight our advocacy efforts this year. We received several questions from ACA members and advocates about our legislative agenda and advocacy efforts.

In the July issue of *Counseling Today*, we shared our answers to some of the questions that we received. This month, we're doing a follow-up and answering still more questions. Should you have any additional questions or feedback for the ACA Government Affairs and Public Policy team, please email us at *advocacy@counseling.org*.

It seems many professions, including certified public accountants, have reciprocity across the U.S. What steps can we take toward obtaining reciprocity for mental health professionals so that we can continue telehealth with our clients who reside or vacation in other states?

ACA began working toward an interstate compact on licensure portability in late fall 2018. ACA has funded the first stage of the interstate compact process in its entirety, including the advisory group composed of subject matter experts tasked with spearheading the initiative. Our advisory group and legal experts have finished drafting the first round of bill language for introduction to state legislatures. Telebehavioral health is included in our work on the interstate compact, so any state that signs the compact will be agreeing to allow counselors to use this modality.

Throughout the duration of COVID-19, we encourage states to work with their governor's office, governor's administration and local licensure boards to ensure that counselors are given consideration when determining emergency policies and implementing new protocols such as those related to telebehavioral health.

What is being done related to the most urgent need for complete access to telehealth services during the coronavirus pandemic?

ACA is working with its branches, chapters and members to ensure they have the information necessary to navigate practice during this time. Detailed guidance can be found on the ACA website at *tinyurl.com/CounselingDuringCOVID19*. Additionally, visit our Government Affairs and Public Policy state issues page for more localized information on governors' orders and policy during this time (from *counseling.org*, click on "State Issues" under the Government Affairs tab). Finally, all ACA members are encouraged to contact the Government Affairs and Public Policy team for support in navigating emergency policy and ensuring that the counseling profession is represented in the implementation of telebehavioral health protocols.

How can counselors advocate to be able to bill for services through Medicaid in Georgia?

To begin advocacy work in your state, please reach out to your ACA state chapter or branch. ACA's Government Affairs and Public Policy team will partner with state branches in support of their policy efforts. The American Counseling Association of Georgia can be reached online at *counseling.org/georgia* or via email at *acaofga@counseling.org*.

How can I, as a graduating clinical mental health counselor, better network to be able to find a job?

Networking involves building long-term relationships and a good reputation over time. Meeting and getting to know people whom you can assist and who can potentially help you in return is the ultimate goal of networking.

There are two types of networking a new professional should consider: personal networking and professional networking. Personal networking includes friends, family members, peers, members of your social networks and members of groups to which you belong. Professional networking includes work colleagues, business connections, and those met through professional memberships and affiliations. Take advantage of local and national conferences for the opportunities they provide to connect with others. These connections could lead to employment opportunities in the future. In fact, the new relationships and contacts made through networking are among the most valuable takeaways from any conference.

Here are a few important tips to consider when networking at a conference:

❖ ***Have clear goals/objectives.*** What is the purpose? What would you like to obtain through networking?

❖ ***Plan ahead.*** Think about the sessions or social events that you will be attending and the specific attendees with whom you would like to connect and interact because of shared interests. Get on the list for dinners, networking events and meetups.

❖ ***Go prepared.*** Do your research on attendees, vendors and speakers. Read their latest books, articles and blogs. Be aware of their accolades and accomplishments. Educate yourself on the latest news involving specific companies and organizations.

❖ ***Be approachable and ready.*** Prepare yourself to be open and engaged. Be willing (and make yourself appear willing) to network and talk with others. You might want to be ready with conversation starters, which you can practice prior to the conference. A few examples: Where are you from? Will you be attending any other conferences this year? What sessions are you looking forward to attending? What do you hope to get out of this conference?

❖ ***Download the conference app.*** The conference app is a great way to stay in the know about networking opportunities beyond the sessions.

❖ ***Bring your networking materials.*** Among items to bring are business cards and copies of your cover letter and résumé/curriculum vitae.

❖ ***Follow up after conference.*** Stay connected by sending a LinkedIn, Twitter or Facebook invite or even a simple email. Send a brief message with your friend request, reintroduce yourself, and thank the person for the time they spent speaking with you. From there, you can suggest an appropriate follow-up.

People with their master's degree in social work can sit for the LPC (licensed professional counselor) exam. Why can't people with their master's degree in counseling sit for the LSW (licensed social worker) or LCSW (licensed clinical social worker) exam?

There are routes within social work education programs that can lead someone to sit for the LPC examination. This is considered the clinical course of study for social workers, which means that their graduate coursework includes specialized advanced courses in human behavior and the social environment, social justice and policy, psychopathology, and diversity issues; research; clinical practice with individuals, families and groups; and clinical practicum that focuses on diagnostic, preventive and treatment services.

These courses are closely related to those within clinical mental health counseling education programs. Completing these courses then qualifies these individuals to sit for the state-required LPC examination. Those who do not pursue the clinical route do not qualify and are unable to sit for the LPC exam.

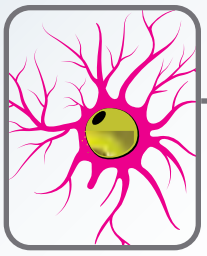
Unfortunately, counseling programs do not have a similar pathway at this time that includes social work courses. Although counselors may have the needed clinical courses and experience, they would be required to pursue social work courses if they were interested in the social work profession. According to the National Association of Social Workers, all credential and specialty holders must have a bachelor's or master's degree in social work; no other degrees are accepted.

Keep in mind that licensure requirements vary from jurisdiction to jurisdiction. Be sure to check with your state board about licensure requirements, statutes and administrative rules. ❖

Brian Banks, Dania Y. Lofton, Dominique Marsalek and Guila Todd make up the ACA Government Affairs and Public Policy Department. Contact them at *advocacy@counseling.org*. Danielle Irving-Johnson is the content project manager at ACA. Contact her at *dirving@counseling.org*.

Coming next month in *Counseling Today*

- Helping clients develop a healthy relationship with social media
- The changing face of student issues during a pandemic
- Counselor clinician vs. counselor educator: Deciding on a career path



The impact of diet and nutrition on mental health, Part 1

By Yoon Suh Moh

In this three-part series, we will explore an intricate mixture of determinants that affect mental health. First, we will examine lifestyle factors (e.g., diet) recognized as modifiable factors for mental health across the life span. Other factors will include the microbiota-gut-brain axis and early life experiences in brain and gut development leading to overall health. The biopsychosocial and lifestyle model will guide clinical case formulation that includes comprehensive assessment (e.g., dietary assessment).

In this month's article, we will cover major topic areas of the lifestyle factors of mental health across the life span and how diet affects human health, especially the onset and persistence of mental disorders. Understanding these areas will help increase clinical competence in counselors, with focus given to holistic, preventive approaches to counseling.

Mental health and well-being

Consistent with the World Health Organization's (WHO) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," mental health does not imply simply an absence of illness. What is the relationship between mental health and mental disorders then?

According to the WHO, mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." According to a 2018 report from *The Lancet* commission on global mental health and sustainable development, well-being is a positive concept that incorporates subjective satisfaction with life and positive affect or mood, and meaningful functioning and human development. In contrast, the commission defined mental disorders as "disturbances of thought, emotion, behavior, and relationships with others that lead to substantial suffering and functional impairment in one or more life activities."

These two states exist on a continuum ranging from normal functioning of being and active participation in life to severe distress and disability, as described in an online course on food and mood offered this year through Australia's Deakin University. It is important to understand that the relationship between the two is not linear. This means that a client with symptoms of a mental disorder (e.g., decreased appetite, loss of interest or pleasure in life activities) and associated emotional distress and disability (i.e., an impairment in function) can still enjoy a certain degree of mental health that aligns with their expectations of being satisfied with their life and achieving their potential to contribute to the community.

Mental health determinants and the GBD

According to Gin Malhi and colleagues writing in the *Australian & New Zealand Journal of Psychiatry* in 2015, mental health is affected by an intricate mixture of social, biological, genetic, developmental, psychological, environmental and lifestyle factors. Joseph Firth and colleagues suggested in *Frontiers in Psychiatry* in 2019 that lifestyle factors (e.g., diet, physical activity, sleep, alcohol and substance use) can affect the development and progression of numerous negative states on the mental health continuum across socioecological and cultural settings.

In a similar vein, findings from the Global Burden of Disease Study 2017 (GBD 2017) are shocking. For example, the GBD 2017 diet collaborators reported that 11 million deaths and 255 million disability-adjusted life years, which allowed for comparison to both years of life lived with disability and to premature mortality, were attributable to dietary risk factors (e.g., high intake of sodium, low intake of whole grains, low intake of fruits) globally. In addition, dietary risks affected people regardless of age, gender and sociodemographic development of their place of residence.

Even as a high-income country in North America, the United States is not an exception to this global health issue. Dietary risks were cited as the third-leading risk factor driving the most deaths and disabilities combined in the United States in 2017, behind only high body mass index (BMI) and tobacco use.

Diet as a lifestyle factor in overall health should attract the attention of counselors, especially when we consider the 28.9% increase in early death and disability nationwide between 1990 and 2016 due to being overweight

(defined as a BMI higher than 25 but less than 30) or obese (BMIs of 30 of higher). Findings from the GBD 2017 suggest that dietary patterns in North America involve approximately 20 grams of processed meat intake per day, when the optimal level of intake per day is less than 5 grams. Additionally, the consumption of sugar-sweetened beverages and sodium per day in North America was about 200 grams and 5 grams, respectively, whereas the optimal levels are close to 0 grams and 3 grams per day, respectively.

In her 2019 book *Brain Changer*, Felice Jacka described this phenomenon of dietary patterns using the term *malnubesity*, which refers to occasions when too much energy is consumed but with very little accompanying nutrition. In other words, the ultra-processed foods that make up so much of the modern diet are high in calories from fats and sugars but very low in nutrients, so they do not provide the nutrition needed for all of the body's processes. According to Jacka, the current food environment has given rise to a common occurrence in which individuals are simultaneously overweight or obese and undernourished — malnubesity.

Diet and depression

According to the GBD 2017, high levels of premature mortality were associated with mental disorders globally. Additionally, R.S. Opie and colleagues, writing in *Nutritional Neuroscience* in 2017, reported that diets higher in junk foods (e.g., sugar-sweetened drinks, fried foods, pastries, doughnuts, packaged snacks, processed and refined breads and cereals) are consistently linked to a higher risk of depression. In contrast, diets higher in whole foods (e.g., vegetables, fruits, whole grain cereals, beans, legumes, nuts and seeds, fish, olive oil) are consistently associated with a reduced risk of depression.

Given these findings, it is important to educate counselors on the current state of dietary patterns in the United States. According to the GBD 2017, in North America (including the United States), the intake of fruits per day was approximately 110 grams (versus the optimal level of 250 grams per day). For vegetables it was 200 grams (versus an optimal level of 350 grams); for legumes it was 30 grams (versus an optimal level of 60 grams); for whole grains it was 30 grams (versus an optimal level of 130 grams; and for nuts and seeds it was 5 grams (versus an optimal level of 20 grams).

Dietary effects on brain development and health

The dietary patterns in North America are quite concerning, not only as they pertain to mental health but also in relation to neurodevelopment and brain health. For instance, Amy Reichelt and Michelle Rank reported in 2017 in *Birth Defects Researc*h that excessive consumption of high-fat and high-sugar junk foods during adolescence might predispose individuals to dysregulated eating and impulsive behaviors by derailing the normal adolescent maturation process in brain regions and influencing neurodevelopmental trajectories.

Additionally, Jacka and colleagues noted in 2015 that lower intakes of nutrient-dense foods (e.g., fresh vegetables, salad, fruit, grilled fish) and higher intakes of unhealthy foods (e.g., roast meat, sausages, hamburgers, steak, chips, soft drinks) were each independently associated with smaller left hippocampal volumes in healthy older adults. Notably, these relationships were independent of the following covariates: age, gender, education, labor force status, depressive symptoms and medication, physical activity, smoking, hypertension and diabetes.

In 2018, Pauline Croll and colleagues reported in the journal *Neurology* that higher intakes of vegetables, fruits, whole grains, nuts, dairy and fish and lower intakes of sugar-containing beverages were associated with larger total brain volume, gray matter, white matter and hippocampal volumes in more than 4,000 individuals in a nonclinical population free of dementia. In a similar vein, Raffaella Molteni and colleagues reported in 2002 in the journal *Neuroscience* that a high-fat and refined-sugar diet reduces levels of hippocampal brain-derived neurotrophic factor, leading to impairments in neuronal plasticity, learning and behaviors.

The hippocampus is responsible for important functions such as memory and learning. Thus, these findings regarding the association between diet quality and patterns and hippocampal volume hold significant clinical implications.

Diet as a moderator of mental health

When working with clients in clinical practice, it is imperative for counselors to actively include diet and nutrition in their clinical conceptualization as major factors contributing to states of being on the mental health continuum and leading to overall health in their clients across the life span. Indeed, diet and nutrition together constitute one of the 17 second-order factors included in the Indivisible Self, an evidence-based model of wellness established by Thomas Sweeney and Jane Myers. Wellness practices are ingrained in our professional identity as counselors. Wellness is a foundational philosophy of our profession, along with prevention and human development across the life span.

In 2015, writing in *The Lancet Psychiatry*, Jerome Sarris and colleagues coined the term *nutritional psychiatry* to promote a new field of research focused on developing a comprehensive, cohesive and scientifically rigorous evidence base to support a shift in thinking around the role of diet and nutrition in mental health. Emerging evidence supports recognition that diet patterns and diet quality influence both physical and mental health.

Jacka and colleagues reported in 2017 that early nutritional psychiatry research largely focused on individual nutrients (e.g., omega-3s) in relation to mental health. However, according to these authors, recent nutritional psychiatry research has headed toward a "whole diet" approach that acknowledges the complexities of nutrients in food, given their synergistic

nature. In 2019, Firth and colleagues also supported this approach, asserting that the relationship between healthy diet and healthy mind was unlikely to persist when examining only specific food groups.

Similarly, interest is increasing surrounding research on *lifestyle psychiatry,* a term popularized by Douglas L. Noordsy in 2019 to describe the role of lifestyle factors in the onset, prevention and treatment of mental disorders. In particular, Firth and colleagues noted that the potential impact of nutrition on mental health was gaining increasing recognition. This was due mainly to large-scale meta-analyses of randomized controlled trials suggesting that both dietary interventions and certain nutrient supplements serving as an adjunctive intervention could significantly reduce various symptoms of mental disorders such as depression and anxiety.

Although a poor-quality diet and its unhealthy patterns are consistently associated with symptoms of mental disorders, findings from randomized controlled trials suggest that diet is a modifiable factor. Results from these trials also support dietary strategies for the treatment of depression. Thus, it is important for counselors to take a holistic approach in collaboration with other health care professionals (e.g., clinical dieticians or nutritionists) to translate the evidence to action.

The need to increase our knowledge base

As mentioned earlier, wellness practices and wellness counseling are at the core of who we are as professional counselors. However, for varying reasons, who we are may not necessarily align with what we actually do in clinical practice.

In a 2020 interview with gastroenterologist Emeran Mayer, Jacka described a survey conducted in the United States in which approximately 75% of participating health care professionals revealed that they had not been trained to provide dietary consultations and recommendations during their preservice education and training. This lack of training may also hold true for mental health professionals in the United States because diet and nutrition are not currently included in the core knowledge areas for entry-level academic counselor education training programs.

As directed by the 2014 *ACA Code of Ethics*, professional counselors must practice in a competent and ethical manner. Clinical competence must be within the scope of the counselor's training, education, knowledge and acquired skills to serve diverse individuals, families and communities. Therefore, counselors are encouraged to increase their knowledge by educating themselves about scientific evidence in relevant areas (e.g., diet and nutrition, lifestyle psychiatry, nutritional psychiatry).

This should also involve counselors familiarizing themselves with existing dietary guidelines. The Food and Agriculture Organization of the United Nations states that more than 100 countries in the world have food-based dietary guidelines. Country-specific guidelines provide culturally appropriate, evidence-based recommendations on healthy diets (see *fao.org/nutrition/education/food-dietary-guidelines/en*). In 2020, Opie and colleagues reported that better adherence to the Australian Dietary Guidelines may have resulted in improved depressive symptoms in more than 800 women who participated in a five-year longitudinal study.

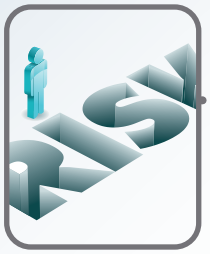
In the United States, the 2015-2020 Dietary Guidelines for Americans (see *tinyurl.com/AmericanDietaryGuidelines*), developed by the Department of Health and Human Services and the Department of Agriculture, are informed by the current scientific evidence on nutrition and health. The Department of Agriculture also provides a practical tool named Choose My Plate (*choosemyplate.gov*) that is designed to help individuals practice following and manage a healthy diet.

Implications for counselors

Lifestyle factors such as diet play a pivotal role in human development across the life span and in mental health, particularly regarding the onset and maintenance of mental disorders such as depression and anxiety. Over the past decade, emerging evidence has suggested that diet is a factor that is more modifiable compared with other determinants (e.g., biological, genetic or environmental factors) and that it can serve as an adjunctive intervention to behavioral health care or psychopharmacological approaches.

Counselors should consider actively taking lifestyle factors, especially pertaining to diet, into account because these factors are among the most critical intervention areas when working with clients who have symptoms of a mental disorder. Before doing so, however, counselors should reflect on their clinical competence to integrate these areas with counseling and proactively seek to increase their knowledge about diet and nutrition relevant to mental health and mental disorders. ❖

Yoon Suh Moh is an assistant professor of community and trauma counseling at Thomas Jefferson University. She is a licensed professional counselor, certified rehabilitation counselor and national certified counselor with professional proficiency in English, Japanese and Korean. Contact her at *yoonsuh.moh@jefferson.edu*.



Risk Management for Counselors

Considerations for continuing a remote counseling practice

By Anne Marie "Nancy" Wheeler

Question: I am what you might call a counselor "dinosaur." I've practiced for many years and thought I would retire before I had to face all the hurdles of telemental health practice. However, when the COVID-19 pandemic hit, I had to jump into the online waters quickly or be unable to serve my clients. I've decided that I may want to continue telemental health but, now that I'm catching my breath, want to make sure I'm doing things correctly. Besides revising my HIPAA notice of privacy practices, do you have any other thoughts about what I might be missing?

Answer: This is an excellent time to consider what you might need to do to continue your new remote counseling practice. Here are a few suggestions.

❖ Don't forget to update your policies and procedures related to HIPAA (the Health Insurance Portability and Accountability Act of 1996). The federal government has extensive guidance materials online addressing both privacy and security. See *hhs.gov/hipaa/for-professionals/privacy/guidance/index.html* and *hhs.gov/hipaa/for-professionals/security/guidance/index.html*. Compare these guidance materials with any state requirements for counselors in the state where you are licensed.

❖ Are you using a secure platform, based on the guidance above? It's often useful for counselors (especially "dinosaurs"!) to obtain help from an information technology expert.

❖ Consider revising your informed consent document to address counselor obligations and client rights and responsibilities concerning telemental health. Also, remember to speak with your clients; informed consent involves both oral and written notification. Revisit the issue periodically because informed consent is a *process*, not a static one-time requirement.

❖ Are you licensed where your clients are located? Check licensure requirements if you are practicing beyond the boundaries of your state of practice. Review Section H of the 2014 *ACA Code of Ethics*, which addresses distance counseling, technology and social media. The ethics code is readily accessible at *counseling.org/resources/aca-code-of-ethics.pdf*. Also, remember that American Counseling Association members may obtain consultation on ethics questions by calling 800-347-6647 ext. 321.

Additionally, some states have given limited temporary authority to provide teletherapy and related services during the COVID-19 pandemic. Check with your own licensure board to see what details apply in your state. You will be responsible for following up when the state of emergency ends. This entails planning ahead to avoid client abandonment and helping the client make a transition to another mental health practitioner, unless you are otherwise authorized to practice in the other state.

❖ Have you addressed the issue of continuity of care with your clients and what procedures and notifications would kick into place if you were to become seriously ill or unavailable? We've discussed this topic in prior columns, but counselors clearly cannot avoid it any longer. See *privatepracticepreparedness.com* for more information.

❖ Address issues of health insurance coverage with your clients. When the pandemic eases or a vaccine becomes available, you will need to verify continued insurance coverage should you and your clients choose to continue telemental health services. ❖

Anne Marie "Nancy" Wheeler acted as the American Counseling Association's risk management consultant for 30 years. She has retired from the practice of law in Washington, D.C., and Maryland but continues to write on issues of mental health risk management. The information presented here is for educational purposes only. For specific legal advice, please consult your own local health care attorney.

Private Practice Strategies

Growing your client base during the pandemic

By Deb Legge

Marketing your private practice during the COVID-19 pandemic can seem like a big challenge. Many referrers are too busy to chat and are restricting their offices to meet acceptable guidelines. It might seem impossible to get your name out there to attract more referrals. You may feel like a bother or that asking for clients during this time is something that won't be well received.

The truth remains, however, that you need a steady stream of clients to stay in business. Whether you are seeing clients in person or have transitioned to a virtual (or hybrid) model, you need to fill your book.

Another truth that you may not be considering in the midst of your angst over marketing is that *people need you more than ever right now*. Referrers may not have the time to meet, and your marketing strategies may need to be tweaked to fit the realities that currently exist, but there is no reason that you cannot be as busy as you'd like to be, even during this pandemic.

Marketing can be intimidating for most of us. After all, we weren't trained as salespeople in our graduate programs. However, *if you're in business, then you're in sales*. Without sales, your book won't be full, and you'll likely be forced to close your doors. I appreciate any discomfort that you might have in reaching out, so let's start with a strategy that may feel a lot more benign to those of us who are looking to get noticed and to gain credibility, likability and trust.

No matter what is happening in the world, the reality is that *people do business with people they know, like and trust*. This two-part series is about taking action on your goals: to get noticed; to gain credibility and likability; and to earn people's trust (and in the process, to fill your book). This month, we'll stick to familiar ground. Let's start by focusing on the folks you know and how to access and serve them — even during the pandemic.

Networking

Your "network" is made up of the people you already know. They are your supporters and fans or otherwise know you well enough that they'd at least return a call when you reach out to them. They are people you would feel comfortable talking with over coffee or on Zoom. Your network includes:

- Friends
- Family
- Colleagues
- Grad school cohorts
- Existing referrers
- Professionals you know

Benefit to you: These folks might care about you. They might have benefited from knowing you in the past. You already have an "in" if you think about it. They may have an interest in your success. They require less "care and feeding" if you do it right. You can count on them.

Benefit to them: You are a known entity. This relationship is already laced with trust, respect, credibility and experience. They can count on you.

Don't take for granted that everyone in your network already knows why you are the person to call when it comes to providing services. *Everyone* in your network should know:

- Who you are
- Whom you serve
- Why you do it
- How you can help them (or help them to help others who are important to them)

Action plan

This week, take these steps:

- Create a list of 60-90 folks in your network (people you already know).
- Organize their contact information so that it's easy for you to access (this makes you more efficient).
- Schedule a time each week to reach out and get in touch with two or three people from your list (that's equivalent to contacting each of the people on your list about twice a year).

Here are a few tips:

- You can count the "organic" contacts (collaborations, holiday cards, shared events, etc.) just as long as you are thoughtful and intentional about those contacts.
- Determine how you will reach out in advance (email, phone call, snail mail, etc.). Think about which methods might increase your chances to connect (again, for efficiency).
- Keep your eyes open for links, books, references, invitations for coffee (or virtual coffee dates), offers to help, or introductions to others you know that might benefit those in your network. Sharing valuable things that benefit *them* gets you noticed and increases your credibility, likability and trust.

The following week, take these steps:

- Reach out to the first two or three people on your list. Be prepared to touch base, check in on them, find

out what and how they are doing, or discover what special or different needs or circumstances may exist for them during the pandemic that you can assist with.

❖ Record your actions and results, along with a plan for following up (and then schedule those times in your calendar). Document your correspondence (written and otherwise) so that this becomes an organized and efficient effort.

Here are some hints:

❖ Going about this process with a curious mind and a heart of "How can I help *you*?" may be just the paradigm shift you need to make reaching out less stressful or painful.

❖ Remember that this type of contact is about *connecting* in a meaningful way — a way that allows you to learn more about the person and show that you care. While doing so, you will have the opportunity to educate or remind the people you already know about what you do in terms of how it might best benefit them.

If your goal is to fill your book and have a successful, sustainable private practice — even during a pandemic — remember: A goal without action is just a dream. *Now* is your chance to show yourself just what you're willing to do to get what you say you want.

Follow this action plan, and next month we'll broaden the scope. I'll show you even more opportunities to succeed in even bigger ways — no matter what. ❖

Deb Legge is a licensed mental health counselor, a speaker, a coach and a private practice mentor. Over the past 26 years, she has helped thousands of therapists achieve success with private-pay private practices. She has educated and empowered clinicians nationwide to grow thriving, sustainable practices faster than they thought possible. Contact her, and engage in her free training, at *PrivatePayPractice.com*.

Counselor Career Stories

Exercising 'power with' rather than 'power over'

Interview by Danielle Irving-Johnson

Shekila Melchior is a national certified counselor and a licensed professional school counselor in Virginia. She is currently an assistant professor at George Mason University in Fairfax, Virginia. Prior to joining faculty life, she was a high school counselor in Bassett, Virginia. She has also worked as a mental health therapist on an inpatient psychiatric unit.

Shekila Melchior

Melchior received her doctorate from Virginia Tech in 2017 and holds a master's degree in school counseling from North Carolina A&T. She serves as a member of the Counselors for Social Justice Curriculum Task Force. She is also the president of the Virginia Alliance for School Counseling, a division of the Virginia Counselors Association.

Melchior's research interests include social justice identity development, undocumented students/immigrants, the professional identity development of school counselors, and human trafficking. Her advocacy efforts are focused on two main areas: race and immigration issues surrounding the undocumented population.

Danielle Irving-Johnson: What initially led you down the path toward a career in the counseling profession?

Shekila Melchior: I originally went to school to be a lawyer, a dream I had since childhood, but I had some serendipitous moments in undergrad that led me to counseling. I switched majors to criminal justice, deciding I would rather be a juvenile court counselor than a lawyer. I interned with the juvenile justice department and would have to pick kids up from their home or school to take them to juvenile detention. I would also visit them in level four lockdowns.

There was something in me that felt disheartened about incarcerating children, and it was during my senior year of college that I felt it would be better for me to *prevent* rather than to *incarcerate*. The best way for me to do that was to become a school counselor.

DIJ: What do you consider the most essential traits for a counselor to have?

SM: Compassion, humility, resiliency, self-awareness and passion.

DIJ: Considering the current and ongoing social injustices that many marginalized populations are faced with, what do you see as the role of professional counselors and educators as it relates to this issue?

SM: I believe the role of the counselor in this season specifically is to *act*. At some point in time, we have to move beyond a place of cultural competency and act on the knowledge and awareness that we have gained. Think outside the box and remain cognizant of the communities that need services but aren't receiving them or don't know how. I think we are well beyond the place of just putting out statements and developing task forces. There is a sense of urgency that is asking us to do more.

DIJ: Considering your journey in the counseling profession thus far, what has been your most valuable lessoned learned, and what advice would you offer to a new counselor?

SM: In my master's program, I was given a piece of advice that still holds true to this day, and I tell my students this as well: "Care but don't carry." The clients and students we serve, we care for them and their wellness, but we don't carry their burdens.

I subscribe to a relational-cultural approach where connection is fostered through relationship, mutual empathy and mutual empowerment. I believe in having "power with" my client or student and not "power over." So, in terms of advice, remember that you are a facilitator. Your client or student chooses to change; the onus should always be on them. The minute you take that from them, you have stripped them of their power and agency to be an active agent in their healing. Ultimately, we want to empower them, as they are the experts of themselves and their life experience.

DIJ: You have served in many roles as a counselor, school counselor and counselor educator. What has the transition been like for you, and how have you maintained a balance between multiple professional identities and roles?

SM: My transitions have been interesting to say the least. My counselor identity is firmly rooted in school counseling. I believe watching a child develop and grow within the context of many systems is powerful, humbling and encouraging.

When I transitioned to counselor education, I worked really hard to maintain a school counselor identity that I feared I would lose in the academy. Continuing work in schools

has proved beneficial for me, [as has] working with children in private practice. My hope is that school counselors will have a more defined and strengthened home in the American Counseling Association.

DIJ: What impact has the pandemic had on the way you work, and how have you adapted to the new normal?

SM: So, I teach at George Mason University, which is a brick-and-mortar school, and the classes I teach didn't lend well to online learning — my social justice in counseling class specifically. It was definitely an adjustment for me. The ambiguity was difficult at times.

I think extending myself and my students grace was the best thing I could do. I believe that in modeling that, they in turn will remember the times they need to extend their future clients and students grace.

In private practice, we work with children. While teenagers have naturally adapted to the online space, it is an adjustment for elementary-age children who thrive off of play and engagement.

DIJ: What do you see as the biggest challenge we face as a profession?

SM: I want to respond to this specific question with three points:

- Unification in the field, specifically as it relates to reciprocity across states
- Unification and collaboration in the field at national and state levels between the school counseling field and the clinical mental health field
- Advancing our profession to further engage liberation, anti-racist, and intersectional and social justice practices

DIJ: What do you do outside of work to prevent burnout and maintain a healthy, well-balanced life?

SM: I am a huge fan of the salsa and bachata classes I take. It is one area in my life that exercises a different part of my brain. I can learn from someone else, and there are no expectations of me to be the "expert." Aside from that, I enjoy walks, Audible books and crafting.

DIJ: The American Counseling Association has more than 52,000 members. Is there anything else that you wish to share about yourself or your work?

SM: I just want to acknowledge the amazing private practice I work for, The Wise Family (*thewisefamily.com*), which does such great work, and the nonprofit organization, Fail Safe-ERA (*failsafe-era.org*), where I serve as the director of preventing generations of incarceration. ❖

Danielle Irving-Johnson is the content project manager at the American Counseling Association. Contact her at *dirving@counseling.org*.

CEO's Message

Continued from page 7

Please contact me with your suggestions.

I say this all the time: Professional counselors are needed now more than ever. Many of us are familiar with the statistics that indicate the depth of mental health challenges facing our society. Counselors have been creative and committed in their efforts to continue providing services, even when the ways in which many of you worked have been upended. I have never been prouder of how professional counselors are helping society, and I am grateful for all you are doing.

As always, I look forward to your comments, questions and thoughts. Feel free to call me at 800-347-6647 ext. 231 or to email me at *ryep@counseling.org*. You can also follow me on Twitter: *@Richyep*.

Be well. ❖

Ethics Update

Counseling ethics during times of uncertainty

By Everett Painter

Counselors are no strangers to working with difficult issues during difficult times. We routinely find ourselves in a position of not knowing and must learn to tolerate degrees of uncertainty as we work to address the needs of our clients. Perhaps nothing causes us to face this challenge more squarely than times of natural and human-made disasters or mass-scale events such as the pandemic that is currently sweeping the globe.

At the start of the restrictions resulting from COVID-19, counseling students and practitioners alike were immediately faced with the need to adjust their way of working with clients. In the haste to find solutions, and in light of other news such as temporarily modified HIPAA restrictions, it might have been easy to jump into situations without giving full consideration to issues relative to ethics. As we navigated a rapidly changing situation and found ways to address these concerns, however, it became clear that ethics remain critical during times of crisis. And although the magnitude of uncertainly is often beyond our control, the guidance provided by ethical sensitivity may serve to diminish it.

Responsible adjustment

We are often called to assist our clients with changing situations — to help facilitate a successful adjustment to the new. During times of uncertainty, the tables are turned because helpers must also scramble to adjust. For example, COVID-19 upended a fundamental element of our work as physical distancing halted most face-to-face interactions. This and other new realities introduced during times of crisis elicit a host of questions relative to competence.

Do I understand my state regulations regarding disaster assistance? What liability issues might I face by getting involved? What information do I need to tell clients? How does this type of work affect informed consent and professional disclosures? Are alternate modes of delivery covered by my professional liability insurance? How can I help clients who are experiencing financial upheaval or, in the case of the current pandemic, those facing virus-related xenophobia and other social responses? Answers to these and other questions often raise further points for consideration and adjustment.

The complexity of these new challenges requires us to maintain high standards of competence as discussed in Section C: Professional Responsibility of the 2014 *ACA Code of Ethics.* Self-awareness and honest evaluation serve us well as we attempt to address these important questions. We must be diligent and intentional as we strive to uphold our responsibilities to the public.

The therapeutic space

Our dilemma is not over once we have a handle on these primary questions. While we know a great deal about elements that contribute to an effective therapeutic relationship, they tend to be relative to the core conditions. Very little attention has been focused on the role played by actual physical space. This is true even though early studies of mental health institutions concluded that physical designs alone could contribute to a worsening of client symptoms. A reconsideration of the therapeutic space is necessary when we are removed from the conventions of our offices.

Let's again use COVID-19 as a scenario for this discussion. It may be difficult to ensure the security of our communications when working from home. For example, aside from technological issues, we may find ourselves living and working in shared spaces with partners and children. And during natural disasters, we are often working from the field. We may be interviewed by members of the media or have a need to interact closely with other groups and organizations. Care is needed to maintain privacy. We must always evaluate client safety and confidentiality within context.

Standard B.1. Respecting Client Rights underscores the importance of confidentiality for maintaining trust and the integrity of the working alliance. It is clear that regardless of our environmental situations, we are to provide a therapeutic space that affords privacy to and maintains the confidence of the client. Confidentiality must always remain at the forefront.

Value imposition

Our values guide our day-to-day interactions. Most clinicians concede it is unlikely that we will be able to consistently and fully remain neutral or value free in our professional practice. This does not mean that we give up and do what we want. Rather, we embrace that fact and strive to be fully aware of our attitudes and beliefs. In doing so, we can more effectively avoid blind spots and navigate complicated situations. This is a critical disposition to adopt

long before being confronted with crises because it is easier to lose our objectivity during times of high stress.

Standard A.4.b. Personal Values notes the need for self-awareness as we work to avoid imposing our values. Our job is to help clients find answers most congruent with their own values. In a crisis or disaster scenario, this means paying special attention to cultural sensitivity, respecting autonomy and bracketing to avoid bias.

Professional support

All of these concerns highlight the need to maintain our own supportive professional networks. Having a group of peers with which to discuss concerns is important when seeking feedback and trying to gain (and maintain) one's footing.

Additionally, supervision may be crucial to helping us navigate the myriad new issues we face during times of uncertainty. Standard F.1.a. Client Welfare discusses the important role of supervision relative to client safety. Developing such a support network ahead of crisis situations is invaluable and allows us to do our best work.

Self-care

Managing the challenges introduced by uncertain situations can be a tall order. Boundaries may become blurred as we attempt to juggle multiple work and personal roles. We may find ourselves interacting differently with clients. Or we may face the detrimental impact of issues such as burnout and vicarious trauma. It is important to remain mindful that, like our clients, we may also be experiencing significant stress as our lives get disrupted, our routines are changed and our traditions are lost.

Section C: Professional Responsibility calls for us to practice self-care. Yet we know that during times of normalcy, clinicians often fail to follow their own self-care plans or other available opportunities. The danger of such failings only increases during times of crisis. So, we must be vigilant.

Develop a structure and stay on schedule. Find ways to separate work from other aspects of your life. Engage in activities that allow for positive connection. And make such plans a priority.

Decision-making

Very little of what we do in counseling is black and white. Therefore, the *ACA Code of Ethics* should not be thought of as a blueprint. It does not tell us exactly what to do. Rather, it is more accurate to view it as a road map containing a variety of routes. It provides a general direction to our destination. But we must remember that we will encounter twists, detours and barriers along the way.

With this orientation in mind, it is advantageous to consult a decision-making model. This is especially true during periods of high stress and emotion. The foundational principles of our ethics (autonomy, nonmaleficence, beneficence, justice, fidelity and veracity) serve as guideposts along the way. At no time are these qualities needed more than in the face of great uncertainty.

Taking deliberate steps can help light an otherwise darkened path and offer clarity. Such intentionality is needed if we are to maintain our credibility as thoughtful, culturally relevant and ethical practitioners. ❖

Everett Painter is an assistant professor of counseling and the department co-chair for counseling, school psychology and special education at Edinboro University. He is a member and the junior co-chair of the ACA Ethics Committee. Contact him at *epainter@edinboro.edu*.

Bulletin Board

FYI

AHC Emerging Leaders Program

The Association for Humanistic Counseling's Emerging Leaders Program was developed to allow students and new professional leaders to participate in AHC activities, receive regular mentorship, and connect with opportunities that will help them grow as leaders. Emerging leaders will be selected to serve for the July 2021-July 2022 term. Master's-level students, doctoral-level students and new professionals are encouraged to apply. More information about the program and the application process can be found on the AHC website at *humanisticcounseling.org*. All application materials are due no later than Dec. 1. For questions about the AHC Emerging Leaders Program, contact the program chair, Christina Woloch, at *ahcemergingleaders@gmail.com*.

Climate in crisis: Counselors needed

Counselors have a role to play not only in helping clients cope with the mental health effects of climate change but also in fostering climate resilience in communities

By Laurie Meyers

On a warming planet, some of the most rapid increases in temperature are being experienced in the Circumpolar North — the area within and, in some cases, just below the Arctic Circle. Overall, the average global temperature has increased by 1 degree Celsius (1.8 degrees Fahrenheit) since 1880. Two-thirds of that rise has occurred since 1975.

Since the 1990s, warming in the Arctic, in particular, has been accelerating. Researchers say the region is warming two to three times more quickly than the rest of the planet. In some areas such as Canada's Labrador coast, the annual average temperature has increased as much as 3 degrees Celsius (5.4 degrees Fahrenheit), causing drastic changes in the weather, terrain and wildlife.

This coastal region is home to the Labrador Inuit people, who live in Nunatsiavut, a self-governing Indigenous territory with five communities — Nain, Hopedale, Postville, Makkovik and Rigolet — accessible only by airplane. The communities are not connected by roads. Instead, navigation is via paths over increasingly unstable ice, which is now prone to sudden thaws and pitted with holes. Unpredictable seasons and severe storms have also made it more difficult for the Inuit to get out on the land that has sustained them physically and spiritually for generations. Like other Indigenous peoples, the Labrador Inuit have faced displacement and forced assimilation. Traditional activities such as fishing, trapping, hunting and foraging are not just for subsistence; they are essential practices that undergird the Inuits' culture and identity. Climate

> For us, going out on the land is a form of spirituality, and if you can't get there, then you almost feel like your spirit is dying.

change has disrupted all of this, not only through changes in the ice, but through changes in the wildlife and plants.

But it goes even beyond that. Climate change is affecting the mental health of this region's residents.

In 2012, the leaders of the communities of Nunatsiavut asked Inuit and non-Inuit researchers to conduct a regional study of the effects of climate change on mental health. More than 100 residents were interviewed as part of a multiyear study. The resulting report shed light on the strong emotions and reactions of the interviewees, who expressed fear, sadness, anger, anxiety, distress, depression, grief and a profound sense of loss.

One of the interviewees attempted to convey what the land represents to the Inuit: "For us, going out on the land is a form of spirituality, and if you can't get there, then you almost feel like your spirit is dying."

A community leader expressed an existential fear: "Inuit are people of the sea ice. If there is no more sea ice, how can we be people of the sea ice?"

Ashlee Cunsolo, a public health and environmental expert who was one of the lead non-Inuit researchers, believes that grief — ecological grief, as she and other researchers have dubbed it — is inextricably linked with climate change. She defines it as "the grief felt in relation to experienced or anticipated ecological losses, including the loss of species, ecosystems and meaningful landscapes due to acute or chronic environmental change."

A clear and present concern

The story of the Labrador Inuit is undeniably heart-rending. Even so, most people probably feel that scenario is pretty far removed from their own lives and losses. After all, as global citizens of the 21st century, our lives are increasingly virtual, and even if we enjoy the great outdoors, the idea of everything we are being bound to a particular land or place may seem alien.

Think about it a little more though. Whether our settings are urban, suburban or rural, most of us have geographic preferences, be they coastal, mountain, bayou, prairie, desert, forest or canyon. It might be where you live now or where you grew up, but it calls to you. And it has changed. That pond where you spent your childhood winters ice-skating no longer freezes hard enough to handle your gliding blades. Your favorite beach keeps losing feet of sand to the ocean. Ski season is now short on both time and fresh powder. Fire is prohibited at your favorite campsite. The city where you live has endured a summer string of 90-plus-degree days, leaving you longing for fall, but that season of cool, crisp air is increasingly elusive. The heat lasts well into September and October, as trees in your neighborhood stubbornly stay green — until they turn brown.

Austrian environmental philosopher Glenn Albrecht calls that feeling — a sense of missing a place that you never left because it has been altered by climate change — *solastalgia*.

"I think place can be really underestimated, but place attachment is such a part of who we are," says Debbie Sturm, an American Counseling Association member who serves on the organization's Climate Change Task Force. "If there's harm in a place or threat to a place or loss of place, it is a significant loss."

As an example, the diaspora caused by Hurricane Katrina in 2005 was extremely traumatic, says ACA member Lennis Echterling, a disaster, trauma and resilience expert who provided mental health support in New Orleans in the wake of the storm. In some cases, people desperately fleeing the floodwaters and destruction were barely aware of where they were headed. Many of those who evacuated have never returned.

"There is still a population who have been separated from their homes — their sacred ground," says Echterling, a professor at James Madison University in Harrisonburg, Virginia. Although that phrase, *sacred ground*, is most often associated with tribal populations, Echterling believes it is true for all of us — that we all have an intrinsic attachment to place. And climate change will continue to separate people from their homes, he says, citing researchers who forecast that by the year 2050, an estimated 1 billion people worldwide will be climate refugees.

Even those who haven't been displaced or experienced climate catastrophe may find it hard to avoid a creeping sense of existential dread — or *ecoanxiety* — as they witness or hear about extreme weather event after extreme weather event. On June 20, the temperature in the Siberian town of Verkhoyansk reached 100 degrees Fahrenheit, the hottest temperature ever recorded north of the Arctic Circle. Researchers say such an occurrence would be almost impossible (a once-in-80,000-years happening) without climate change caused by human activity. In recent years, wildfires have reduced entire California communities to ash, with citizens up and down the coast donning masks to protect themselves from a lingering pall of

> The ACA Climate Change Task Force views the counseling profession's strengths-based approach and focus on resilience as essential to responding to those affected by climate change.

smoke. In 2018, Hurricane Florence turned Interstate 40 in North Carolina into a river. Hurricane Harvey struck Houston repeatedly over six days in 2017, leaving one-third of the city underwater at its peak. Approximately 40,000 Houston residents had settled in the city permanently after evacuating from Katrina more than a decade earlier.

Every year, the signs of a climate crisis grow more alarming, and the psychic toll can be traumatic. Psychiatrist Lise Van Susteren, an expert on the mental health effects of climate change, coined the phrase "pretraumatic stress disorder" to describe the fear that many individuals are experiencing about disasters yet to come.

Since 2008, the Yale Program on Climate Change Communication and the Center for Climate Change Communication at George Mason University have been conducting national surveys biannually to track public understanding of climate change. The latest survey results, from November 2019, indicated that 2 in 3 Americans were at least "somewhat worried" about global warming, whereas 3 in 10 were "very worried" about it. A majority of those surveyed were worried about the potential for harm from extreme events in their local areas.

The mental health effects related to climate change extend beyond disasters such as hurricanes and wildfires. Research has indicated a link between rising temperatures and the increased use of emergency mental health services, not just in places that regularly experience hot weather, but in relatively cool areas as well. Higher temperatures have also been tied to increased levels of suicide.

As the ACA Climate Change Task Force reports in its fact sheet (currently under review), experts predict a sharp rise in mental health issues such as depression and anxiety, posttraumatic stress disorder, substance abuse and suicide, in addition to outbreaks of violence, resulting from coming climate crises. The task force views the counseling profession's strengths-based approach and focus on resilience as essential to responding to those affected by climate crisis.

However, as part of a study that has not yet gone to press, Sturm, fellow ACA and task force member Ryan Reese, and ACA member Jacqueline Swank surveyed a group of counselors, social workers and psychologists about their personal and professional perceptions of climate change. Although Sturm, Reese and Swank found that these helping professionals were more likely than the average person to believe that climate change is real, very few felt the issue was relevant to their professional lives. Many respondents also said that they didn't feel confident addressing issues related to climate change in their practice.

Climate change in the counseling office

Reese, a licensed professional counselor practicing in Bend, Oregon, believes that not knowing how to define — and, thus, recognize — climate concerns is part of counselors' discomfort.

"What is climate change?" he asks. "Is it when you live in California and no longer have a home? … Is it a climate issue when a client is just talking about the general state of affairs and worrying about the world for their kids?"

Of course, there is also the matter of climate change being a polarizing topic, says Reese, an assistant professor of counseling and director of the EcoWellness Lab at Oregon State University-Cascades. When he is talking with clients about broader health and wellness and the topic of climate change comes up, sometimes they will tell him they think it is fake news. "What am I going to do?" Reese asks. "Am I going to impose my view? How do we find ways to introduce our wellness perspective without imposing?"

Reese's practice is based on ecowellness, a model he co-developed with Jane Myers that revolves around a neurobiological relationship with nature. "The bridge here is, 'Tell me about your relationship with nature,'" he says.

Reese says he does see a significant amount of ecoanxiety and fear of the unknown, especially among his adolescent clients. But they typically come in talking about depression.

Reese's intake process includes questions about spirituality and life's meaning and purpose. He asks clients about their outlook on the future, which is where their anxiety sometimes emerges. Questions about their relationship with nature often reveal the connection between that anxiety and their concerns about the climate.

If clients mention any angst about the environment, Reese asks whether they can unpack that a little more. He'll follow up by asking questions about how a client spends their time outdoors, what their everyday access is to nature, where and how they feel most effective in nature, and whether

they have any hobbies involving nature. He also encourages them to think about what role they can take on: "You mentioned being fearful about what your future is going to hold. What, if anything, can you do right now to address your concern about environmental crisis? … What is within your immediate grasp and control that you can do?"

Reese's approach involves seeing what the individual's broader landscape looks like and what their interests, passions and resources are. He urges his clients to get creative and often suggests that his adolescent clients take some kind of action at school, such as starting a recycling program. One of his adult clients took the action step of buying an electric bike and not driving his car as frequently to lessen his impact on the environment.

Reese also helps clients connect their hobbies with environmental action. For instance, if they like skateboarding, he'll ask them what kind of impact they think that has on the environment. That may lead them to taking the action step of picking up trash around the skate park.

"It's looking at what is the way we can increase self-efficacy in response to the environment so that it's not abstract," he says. "This is something I can engage in and learn and sustain this particular activity for myself and other people."

Reese also asks clients to educate him about their activities. "For example, mountain biking is huge in Bend, but I don't know anything about it. … What is the environmental impact? Oh, you don't know either? Where can we find out?"

Climate change as social justice

ACA's Climate Change Task Force notes that the resulting trauma from climate change has been and will continue to be experienced disproportionately. Black, Indigenous and people of color (and their communities), children, pregnant women, older adults, immigrants, individuals with limited English proficiency, those with disabilities, and those with preexisting and chronic

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)

- "Preparing for the mental health impact of climate change" by Debbie C. Sturm & Lennis G. Echterling
- "Lending a helping hand in disaster's wake" by Laurie Meyers
- "Disasters and us" by Cirecie West-Olatunji
- "The high cost of human-made disasters" by Lindsey Phillips
- "The Counseling Connoisseur: Mental health cleanup following a natural disaster" by Cheryl Fisher
- "Using nature as a therapeutic partner" by Lindsey Phillips
- "Ask your doctor if nature is right for you" by Bethany Bray
- "The Counseling Connoisseur: Nature-informed counseling for children" by Cheryl Fisher

Books (counseling.org/publications/bookstore)

- *Coping Skills for a Stressful World: A Workbook for Counselors and Clients* by Michelle Muratori & Robert Haynes
- *Disaster Mental Health Counseling: A Guide to Preparing and Responding,* Fourth Edition, edited by Jane M. Webber & J. Barry Mascari
- *Introduction to Crisis and Trauma Counseling*, edited by Thelma Duffey & Shane Haberstroh

Continuing Professional Development: Multicultural Products (aca.digitellinc.com/aca/specialties/158/view)

- "Counseling Refugees: Addressing Trauma, Stress and Resilience" with Rachael D. Goodman
- "Addressing Clients' Experiences of Racism: A Model for Clinical Practice" with Scott Schaefle & Krista M. Malott

ACA Mental Health Resources (counseling.org/knowledge-center/mental-health-resources/)

- Trauma and disaster
- Family separation
- Grief and loss

medical conditions are all more likely to be affected by climate crisis and to have fewer resources to cope with its impact.

In September, the Gulf Coast will mark the 15th anniversary of Hurricane Katrina, one of the most powerful Atlantic storms on record. It wrought widespread devastation and flooding, including the overflow and eventual break of the levee system around New Orleans. As a result, 80 percent of the city was submerged underwater.

New Orleans and Katrina are important to the discussion of climate change as a social justice issue for a number of reasons, says Cirecie West-Olatunji, a past president of ACA who now lives and works in New Orleans. "Katrina was our first uber-disaster related to climate change," she says. "It informed the world and was a global example of what was to come."

West-Olatunji provided disaster mental health assistance in the aftermath of Katrina. "I could see the gaps," she says. "The normal [disaster] response was not going to be sufficient." Specifically, she recognized that the recovery period would be lengthy, the trauma and mental health challenges extensive, and the reconstruction resources unequally distributed.

Foreshadowing the 2017 tragedy of Hurricane Maria in Puerto Rico, the federal government's response to Katrina was inadequate. It highlighted an essential barrier to recovery, namely that "whatever disparities exist prior to a disaster will be exacerbated post-disaster," says West-Olatunji, an associate professor and director of the Center for Traumatic Stress Research at Xavier University of Louisiana.

Racial injustice, economic instability, and government funding for economic development that was distributed to certain communities and not to others were among the factors that magnified the physical and mental damage left behind by Katrina. And those factors continue to hinder recovery today. "Fifteen years later, and New Orleans is still in trauma mode," West-Olatunji asserts.

There were multiple levee breaches, but only one adjacent neighborhood — the historically Black Lower Ninth Ward — was all but written off from the beginning of the recovery period, West-Olatunji says. Many of the residents owned their homes but faced multiple barriers to rebuilding. One of the most significant factors was discrimination in the distribution of Louisiana's "Road Home" rebuilding funds. According to the Greater New Orleans Fair Housing Action Center (one of multiple plaintiffs in a lawsuit against the U.S. Department of Housing and Urban Development and the state of Louisiana), the program's own data showed that Black residents were more likely than White residents to have their grants based on the much lower prestorm market value of their homes rather than on the actual cost of repair. Other displaced residents were unable to return and now cannot afford to pay their homeowners taxes, West-Olatunji says.

In the Lower Ninth, what's left is an economic and food desert, with virtually no stores beyond a few mom and pops and only one school, she says. Developers have bought up properties, and instead of properly renovating them by gutting and bleaching the houses, in many cases they have simply repainted, leaving renters exposed to toxic mold.

In addition, much of what has been done to "rebuild" New Orleans has rendered it unlivable for those with low and modest incomes, West-Olatunji says. The city bulldozed public housing, and rent has skyrocketed. All of the city's schools are now charter schools, which essentially makes them private schools that don't answer to anyone other than their shareholders, she explains. "Kids are bussed all over the place … having to come out — unaccompanied — before daylight to find their way to school."

New Orleans' primary industry of tourism afforded a modest living to a significant number of residents for many years, West-Olatunji says. Pre-Katrina, that income could purchase a moderately priced house and even allow families to send children to state schools for higher education. Today, she says, the city is "assailed by outsiders and carpetbaggers who buy up properties. … We went from majority home ownership to rentals and Airbnbs."

New Orleans is also a much whiter city now. Although most of the White residents who fled the city due to Katrina have returned, approximately 100,000 fewer Black people currently live in New Orleans than did before late August 2005.

West-Olatunji says there is a frequent refrain from the Black citizens who remained or returned: "I survived Katrina only to deal with the coronavirus and with the latest police brutality."

"The trauma of Katrina was an overlay to existing and continuing stress and racial events," she says. "It makes it really difficult to recover. … People are emotionally exhausted."

Climate change should be of great importance to counselor practitioners, West-Olatunji says. "It's influencing people's behaviors and their possibility of choices. It narrows choices and creates barriers for living. Our job is to assist people in living abundantly. Climate change isn't making that easy," she says.

ACA member Edil Torres Rivera, a professor of Latinx studies and counseling at Wichita State University in Kansas, believes that climate change is still too frequently dismissed as a hoax. "Climate change is something that is real and … has implications for mental health," he says, "particularly for populations like poor people, Indigenous people and people of color."

Anyone who doubts that need only visit Rivera's home island of Puerto Rico, where, three years after Hurricane Maria, people are still trying to recover. He says the urgent nature of the climate crisis is a primary reason that he joined ACA's Climate Change Task Force.

In line with what happened in New Orleans after Hurricane Katrina, Hurricane Maria drove many people out of Puerto Rico, and those who remained faced multiple challenges, particularly around securing federal relief assistance and dealing with severe infrastructure deficits. Most critically, the island's electrical grid was decimated, and it took approximately 11 months for power to be restored to everyone who lost it. But even now, Rivera says, it is still common for people to lose power for several hours whenever it rains. And this past January, a major earthquake left most of the island without power again for several days.

The trauma of Maria was compounded by the stress of the earthquake, which has been magnified even further by the coronavirus pandemic. "People are desperate," Rivera says.

Many children in Puerto Rico are still terrified when it rains heavily and the wind rises, he continues. And since the earthquake, people are often hesitant about sleeping in their houses, so they stay in tents. This scenario will pose a major problem when a hurricane comes, Rivera says.

This past summer in Puerto Rico has been particularly hot, with some days reaching 103 degrees Fahrenheit. Rivera says this is higher than the norm when he was growing up and asserts that it

again points to the effects of climate change. Typically, on hot days, people go to the beach to cool off. But the need to physically distance because of the pandemic has largely eliminated that option. Still, there are thos who, given the oppressive heat, would rather take their chances with possibly being exposed to the coronavirus. Another way that people cool off when it is hot is by having a beer, Rivera points out. He says that climate change has had a hand in sending both drinking and domestic violence rates through the roof for several years. The forced proximity of the pandemic is only exacerbating those trends, he adds.

Building resilience

Professional counselors "need to be involved and aware," West-Olatunji says. "We can't sit back and say that [climate change] has nothing to do with counseling."

In fact, the counseling profession uses a holistic, ecosystemic perspective that looks at all the factors that influence behavior, she emphasizes. To take on climate change, counselors must broaden that model and consider structural interventions that target groups of people and focus on prevention. "Our discipline has always thought that prevention was at the core of wellness," she points out.

West-Olatunji sees a great need for climate change literacy, noting that the people who most need knowledge about the climate crisis — because it is most likely to affect them either directly or indirectly — are also the least likely to have it. Vulnerable communities need to be given more information about how they can mitigate their risk and protect the health and safety of their citizens, she says.

Counselors can assist communities in building climate resilience by using their skills as facilitators to bring people together and help them work effectively as a group, says Mark Stauffer, a member of the ACA Climate Change Task Force. These groups don't necessarily have to be focused specifically on climate change, he says. They could be formed to advocate for

community needs, such as the right to clean water, or something more fun, such as establishing neighborhood gardens.

The essential aspect is to do the group work and to keep bringing people together, he says. "People coming together in times of need — we need to start practicing that now," emphasizes Stauffer, the immediate past president of the Association for Humanistic Counseling, a division of ACA.

If counselors are personally concerned because their communities are not focused on climate change, Stauffer suggests they host a meeting of people who are interested in the topic. "See what people are thinking and where they want to go," says Stauffer, a member of the core faculty in Walden University's mental health counseling program. "It's a process, but that's the good part — connecting and building ongoing relationships. … People in the community need to get used to working together. The dialogue is just as important, if not more important, than the work."

Stauffer thinks that counselors can play a key role in facilitating a new way of being in communities together. He believes that Western society has been living in a kind of empire culture, focused on what can be extracted. The mindset that started with Rome extracting treasures for itself from Europe and then Europe extracting treasures from its colonies has evolved into this sense that survival is about grasping and eking out a living by oneself, he says.

Stauffer says that our collective disaster survivor visual seems to be someone holding an AR-15 rifle in the air, surrounded by their supplies. "That's not where we find joy," he says. "Other cultures have found that surviving and being sustainable is something that we can do together."

We need to find a way to be a part of the Earth in a generative way, Stauffer emphasizes. "The wild is not something to dominate and be afraid of," he says.

Sturm, an associate professor and the director of counseling programs at James Madison University, urges counselors to get involved by finding out if their communities have climate resilience groups. Counselors who are unsure of where to start can bring themselves up to speed by using the U.S. Climate Resilience Toolkit (*toolkit.climate.gov*), a comprehensive resource that explores community vulnerabilities and climate resilience efforts.

Mental Health and Our Changing Climate: Impacts, Implications and Guidance, a 2017 report published by the American Psychological Association, Climate for Health and ecoAmerica, suggests several strategies for mental health professionals interested in promoting community well-being and helping to mitigate climate-related mental health distress. Among the strategies recommended:

- Assess and expand community mental health infrastructure.
- Reduce disparities, and pay attention to populations of concern.
- Engage and train community members on how to respond.
- Ensure distribution of resources, and augment with external supplies.
- Have clear and frequent climate-mental health communication.

"Find out who is doing this in your area. Our voice has to be at the table to talk about trauma," stresses Sturm, who is also currently earning her master's degree in environmental advocacy. "Counselors think this is important, but they're not doing it. … We're not reaching out in our communities as a profession to be part of the discussion." ❖

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

From the President

Continued from page 5

Communicate your services with passion. Aligning your personal values and passion with your business vision and mission will help guide your practice. As counselors, we understand that open and honest communication with our "clients" builds trust. The same is true in business with your "customers." This will help establish your reputation, which is essential to success.

Build your legacy. Building a business and your legacy begins with a vision — or starting with the end in mind. What is it that you want people to remember about you and your business?

You will need a network of people and resources, including family, friends and colleagues, to build your legacy. In addition, you must know your referral sources: people who love your work. It is also useful to volunteer or to take on leadership roles. Identify professional associations, organizations and agencies that you can participate in or otherwise benefit with your skills.

The easiest business to get is "legacy business" or "repeat business" as a result of your clients' and customers' success.

"You have to know what sparks the light in you so that you, in your own way, can illuminate the world."
— Oprah Winfrey ❖

Grappling with compassion fatigue

Counselors and other helping professionals who are regularly exposed to others' trauma almost invariably find themselves confronting symptoms of compassion fatigue at some point during their careers

By Lindsey Phillips

Compassion fatigue presents a paradox for counselors and others in the helping professions. As Alyson Carr, a licensed mental health counselor and supervisor in Florida, points out, it compromises their ability to do the very thing that motivated many of them to enter the field in the first place — empathically support those in pain.

Empathy and compassion are attributes those in the helping professions are particularly proud to possess and cultivate. Yet those same characteristics may leave some professionals more susceptible to becoming traumatized themselves as they regularly observe and work with those who are suffering.

Jennifer Blough provides counseling services to other helping professionals as owner of the private practice Deepwater Counseling in Ypsilanti, Michigan. She says many of her clients experience compassion fatigue. One of her former clients, an emergency room nurse, witnessed trauma daily. One day, the nurse treated a child who had suffered horrendous physical abuse, and the child died shortly after arriving at the hospital.

This incident haunted the nurse. She had nightmares and intrusive thoughts about the child's death and abuse. She started to isolate to the point that she had to step away from her job because she refused to leave her house. She couldn't even bring herself to call Blough. She just sent a text asking for help instead.

Blough, a licensed professional counselor (LPC) and certified

compassion fatigue therapist, asked the nurse to come to her office, but the nurse said she was comfortable leaving her home only when accompanied by her dog. So, Blough told her to bring her dog with her to the session. That got the nurse in the door.

From there, Blough and the nurse worked together to help the client process her trauma. Blough also taught the client to recognize the warning signs of compassion fatigue so that she could use resiliency, grounding skills, relaxation, boundary setting, gratitude and self-compassion to help keep her empathy from becoming unmanageable again.

Defining compassion fatigue

"One of the most important ways to help clients who might be struggling with compassion or empathy fatigue is to provide psychoeducation," Blough says. "A lot of people don't even realize there's a name for what they're going through or that others are going through the same thing."

Blough, author of *To Save a Starfish: A Compassion-Fatigue Workbook for the Animal-Welfare Warrior*, didn't understand that she was experiencing compassion fatigue when she worked at an animal shelter and as an animal control officer before becoming a counselor. After she started feeling depressed, she decided that she was weak and unfit for her job and ultimately left the field entirely. It wasn't until she was in graduate school for counseling that she learned there was a name for what she had experienced — compassion fatigue.

According to the American Institute of Stress, compassion fatigue is "the emotional residue or strain of exposure to working with those suffering from consequences of traumatic events." This differs from burnout, which is a "cumulative process marked by emotional exhaustion and withdrawal associated with workload and institutional stress, *not* trauma-related."

Although compassion fatigue is the more well-known and widely used term, there is some debate about whether it is the most accurate one. Some mental health professionals argue that people can never be too compassionate. Instead, they say, what people experience is *empathy fatigue*.

In an interview with CT Online in 2013, Mark Stebnicki described empathy fatigue as resulting from "a state of psychological, emotional, mental, physical, spiritual and occupational exhaustion that occurs as the counselors' own wounds are continually revisited by their clients' life stories of chronic illness, disability, trauma, grief and loss."

April McAnally, an LPC in private practice in Austin, Texas, is among those who believe that people can't have too much compassion. Compassion involves having empathy and feeling what the other person does, but we have a screen — an internal boundary — that protects us, McAnally says. "Empathy, however, can be boundaryless," she continues. "We can find ourselves overwhelmed with what the other person is experiencing. … So, what we actually become fatigued by is empathy without the internal boundary that is present with compassion."

As Blough puts it, "Empathy is the ability to identify with, or experience, another's emotions, whereas compassion is the desire to help alleviate suffering. In other words, compassion is empathy in action."

McAnally, a certified compassion fatigue professional, also suggests using the term *secondary trauma*. She finds that it more accurately describes the emotional stress and nervous system dysregulation that her clients experience when they are indirectly exposed to the trauma and suffering of another person or animal.

Symptoms and risk factors

Anyone can be susceptible to burnout, but compassion fatigue most often affects caregivers and those working in the helping professions, such as counselors, nurses, social workers, veterinarians, teachers and clergy.

Working in a job with a high frequency of trauma exposure may increase the likelihood of developing compassion fatigue, McAnally adds. For example, a nurse working in an OBGYN office may have a lower risk of developing compassion fatigue than would an emergency room nurse. Even though they both share the same job title, the impact and frequency of trauma is going to be higher in the ER, McAnally explains.

Counselors should also consider race/ethnicity and contextual factors when assessing for compassion fatigue. Racial injustices that members of marginalized populations regularly experience are sources of pervasive and ongoing trauma, McAnally notes. And unresolved trauma increases the likelihood of someone experiencing empathy fatigue, she adds.

Carr, an American Counseling Association member who specializes in complex trauma and anxiety, and Blough both believe the collective trauma resulting from the COVID-19 pandemic and exposure to repeated acts of racial violence and injustice could lead to collective compassion fatigue for all helping professionals (if it hasn't already).

McAnally, a member of the Texas Counseling Association, a branch of ACA, says the current sociopolitical climate has also affected the types of clients she is seeing, with more individuals who identify as activists and concerned citizens seeking counseling of late. She has found that these clients are experiencing the same compassion fatigue symptoms that those in the helping professions do.

Blough and Victoria Camacho, an LPC and owner of Mind Menders Counseling in Lake Hopatcong, New Jersey, say symptoms of compassion fatigue can include the following:

- Feelings of sadness or depression
- Anxiety
- Sleep problems
- Changes in appetite
- Anger or irritability
- Nightmares or intrusive thoughts
- Feelings of being isolated
- Problems at work
- A compulsion to work hard and long hours

- Relationship conflicts
- Difficulty separating work from personal life
- Reactivity and hypervigilance
- Increased negative arousal
- Lower frustration tolerance
- Decreased feelings of confidence
- A diminished sense of purpose or enjoyment
- Lack of motivation
- Issues with time management
- Unhealthy coping skills such as substance use
- Suicidal thoughts

There are also individual risk factors. According to Camacho, a certified compassion fatigue professional, individuals with large caseloads, those with limited or no support networks, those with personal histories of trauma or loss, and those working in unsupportive environments are at higher risk of developing compassion fatigue.

In fact, research shows a correlation between a lack of training and the likelihood of developing compassion fatigue. So, someone at the beginning of their career who feels overwhelmed by their job and lacks adequate training and support could be at higher risk for experiencing compassion fatigue, McAnally says.

One assessment tool that both Blough and Camacho use with clients is the Professional Quality of Life Scale, a free tool that measures the negative and positive effects of helping others who experience suffering and trauma. Blough says this assessment helps her better understand her clients' levels of trauma exposure, burnout, compassion fatigue and job satisfaction.

Regulating the body and mind

"Having an awareness of our emotions and experiences, especially in a mindful way, can serve as a barometer to help protect us against developing full-blown compassion fatigue," says Blough, a member of ACA and Counselors for Social Justice, a division of ACA.

Part of this awareness includes being mindful of one's nervous system and the physical changes occurring within one's body. When someone experiences compassion fatigue, their amygdala, the part of the brain involved in the fight-or-flight response, gets tripped a little too quickly, McAnally explains. So, their body may react as if they are in physical danger (e.g., heart racing, sweating, feeling panicky) even though they aren't.

If clients get dysregulated, McAnally advises them to use grounding techniques to remind themselves that they are safe. She will often ask clients to look all over the room, including turning around in their chairs, so they can realize there is nothing to fear at that moment. She also uses the 5-4-3-2-1 technique, in which clients use their senses to notice things around them — five things they see, four things they hear, three things they feel, two things they taste and one thing they smell.

Research has shown that practicing mindfulness for even a few minutes a day can increase the size of the prefrontal cortex — the part of the brain responsible for emotional regulation, McAnally adds.

Blough often uses the square breathing technique to ground clients and get them to slow down. She will ask clients to breathe deeply while simultaneously adding a visual component of making a square with their eyes. They breathe in for four seconds while their eyes scan left to right. They hold their breath for four seconds while their eyes scan up to down. They breathe out for four seconds while their eyes scan right to left. And they hold their breath for four seconds while their eyes move down to up.

Counselors can also teach clients to do a full body scan to regulate themselves, Blough and Camacho suggest. This technique involves feeling for tension throughout the body while visualizing moving from the head down to the feet. If the person notices tension in any area, then they stop and slowly release it.

Camacho once had a client lean forward and grab the armrest of the chair they were sitting in while talking. She stopped the client and asked, "Do you notice you are gripping the armrest? Why do you think you are doing that?"

The client responded, "I wasn't aware of it, but I find it comfortable. I feel like I'm grounding myself."

Camacho, an ACA member who specializes in posttraumatic stress disorder, trauma, and compassion fatigue in professionals who serve others, used this as a teachable moment to show the client how to ground themselves while also having relaxed muscles. She asked the client to release their grip on the chair and instead to lightly run their fingers across it and focus on its texture.

Carr finds dancing to be another useful intervention. "Engaging in dancing and moving communicates to our brains that we are not in danger. [It] allows us to develop and strengthen affect regulation skills as well as have a nonverbal, integrated body-mind experience," she explains.

Creating emotional boundaries

Setting boundaries can be another challenge for helping professionals. Blough says many of her clients report feeling guilty if they say "no" to a request. They often feel they have to take on one more client or take in one more animal. But she asks them, at whose expense?

Blough reminds clients that saying "no" or setting a boundary just means saying "yes" to another possibility. For example, if a client wants to schedule an appointment on Thursday night at the same time that the therapist's child has a soccer game, then telling the client "no" just means that the therapist is saying "yes" to their family and to their own mental health.

Blough and McAnally recommend that people create routines to help themselves separate work from home. For example, clients and counselors alike could listen to an audiobook or podcast during their commute home, or they could meditate, take a walk or even take a shower to signify the end of the workday, Blough suggests.

"Anything that helps them clear their head and allows them to be fully present for themselves or their families," she adds.

People can also establish what Carr calls an "off switch" to help them realize that work is over. That action might involve simply shutting the office door, washing one's hands or doing a stretch. At the end of the workday, Carr likes to put her computer in a different room or in a drawer so that it is out of sight and mind. Then, she takes 10 deep breaths and leaves work in that space.

Exercising self-compassion

"Because a lot of helping professionals are highly driven and dedicated, they tend to have unrealistic expectations and demand a lot from themselves, even to the point of depletion," Blough says. "Having low levels of self-compassion can lead to compassion fatigue, particularly symptoms associated with depression, anxiety and posttraumatic stress disorder."

In other words, self-compassion is integral to helping people manage compassion fatigue. "Self-criticism keeps our systems in a state of arousal that prevents our brains from optimal functioning," Carr notes, "whereas self-compassion allows us to be in a state of loving, connected presence. Therefore, it is considered to be one of the most effective coping mechanisms. It can provide us with the emotional resources we need to care for others, help us maintain an optimal state of mind, and enhance immune function."

According to Kristin Neff, an expert on self-compassion, caregivers should generate enough compassion for themselves and the person they are helping that they can remain in the presence of suffering without being overwhelmed. In fact, she claims that caregivers often need to focus the bulk of their attention on giving themselves compassion so that they will have enough emotional stability to be there for others.

People in the helping professions can become so focused on caring for others that they forget to give themselves compassion and neglect to engage in

their own self-care. Blough often asks clients to tell her about activities that they enjoy — ones that take their mind off work, help them relax and allow them to feel a sense of accomplishment. Then she asks how often they engage in those activities. Clients often tell her, "I used to do it all the time before I became a professional caregiver."

She reminds them that they can help others only if they are also taking care of themselves. That means they *need* to take time to engage in activities that relax and recharge them; it isn't a choice they should feel guilty making.

Self-regulating in session

As helpers, counselors are likely to experience symptoms of compassion fatigue at some point. This is especially true for clinicians who frequently see clients who are dealing with trauma, loss and grief.

For McAnally, that experience came early in her career. During practicum, she had a client with a complex trauma history who couldn't sleep at night. In turn, McAnally found herself waking up in the middle of the night, worrying about the client. She knew this was a warning sign, so she reached out to her supervisor, who helped her develop a plan to mitigate the risk of compassion fatigue.

It almost goes without saying that counselors should take the advice they give to their own clients: They should establish a self-care routine. They should seek their own counseling and support. They should set boundaries and find ways to recharge outside of work. And they should exercise self-compassion.

But counselors also need to find ways to self-regulate *during* sessions. "If you are tense and you're hearing all of these heavy stories, you're at a much greater risk of being vicariously traumatized," Blough says. Self-regulation can provide a level of protection from that occurring, she notes.

Blough often uses the body scan technique while she is in session. Doing this, she can quietly relax her body without it drawing the attention of her clients. In addition, as she teaches relaxation skills to her clients, she does the skills with them. For example, she slows her own breathing while teaching clients guided breath work. That way, she is relaxing along with them.

Likewise, McAnally has learned to be self-aware and regulate her nervous system when she is in session. If she notices her heart rate accelerating and her stomach clinching when a client is describing a painful or traumatic event, then she grounds herself. She orients herself by wiggling her toes and noticing what it feels like for her feet to be touching the ground. She also looks around the room to remind her brain that she is safe.

McAnally also uses internal self-talk. She will think, "I'm OK right now." As with the body scan, this is a subtle action that clinicians can take to ground themselves without the client even being aware that they are doing it.

Helping the helpers during COVID-19

Recently, Carr received a text from a counseling mentor who has been practicing for 40 years that said, "I am falling apart. I am lost. I don't know what to do, but sending a text to someone I trust felt right. Write or call when you can."

Carr quickly reached out, and her colleague said he was experiencing a sense of hopelessness that he hadn't in many years. He worried about his clients and feared he wasn't doing everything he could for them. He was also anxious about finances; several of his clients had become unemployed because of the COVID-19 pandemic, so he started seeing them pro bono. All of this was taking a toll on him personally and professionally.

Before the pandemic, McAnally managed her compassion fatigue symptoms in part by checking in with other therapists who worked down the hall from her office and by participating in in-person consultation groups. Now that she is working from home full time because of the pandemic, she says that she has to be more intentional about practicing self-care and accessing support. She calls her colleagues to check in, practices mindfulness, and schedules breaks to go outside and play with her dog.

Even when counselors recognize that they need help, they can encounter barriers similar to those their clients face. For instance, they may not be able to find in-network providers, and only a small portion of the hourly rate may be covered by their insurance. This problem made Carr pose some questions: "Who is helping the helpers right now? How can we take care of others if we aren't able to more easily take care of ourselves?"

Then she decided to take action. She created Counseling for Counselors, a nonprofit organization dedicated to raising awareness about the emotional and psychological impact on mental health providers during a time of collective trauma. The organization's aim is to generate funding that would allow self-employed licensed mental health professionals in need of treatment to more easily access those services.

"Although the heightened state of anxiety around the pandemic may have exposed this critical need, the demand for quality, affordable mental health care for counselors is ongoing," Carr says. "Counselors are not immune to trauma and, now more than ever, licensed mental health professionals need access to mental health services in order to effectively treat the populations we serve and to continue to play an instrumental part in contributing to the well-being of society at large."

Fostering compassion satisfaction

People in the helping professions often feel guilty or ashamed about struggling with compassion fatigue. They sometimes believe they should be immune or should be able to find a way to push through despite their symptoms. But that isn't the case.

"I think the biggest takeaway when it comes to compassion fatigue is that it's a normal, almost inevitable consequence of caring for and helping others. It's not a character flaw or a sign of weakness. It's not a mental illness. It affects the best and brightest and those who care the most," Blough says.

For that matter, compassion fatigue isn't something you "have" or "don't have," she adds. Instead, it operates on a spectrum, which is why it is so important for helping professionals to be aware of its warning signs and symptoms.

Blough acknowledges that compassion fatigue is always present in some form for her personally. She often manages it well, so it just simmers in the background. But sometimes it boils over. When that happens, she knows to regulate herself, to increase her self-care and to get support.

It is easy for a negative experience to overshadow a helping professional's entire day and push aside any positive aspects. That's why Blough and McAnally both recommend setting aside time daily to list three positive things that happened at work. A counselor or other helping professional could focus on the joy they felt when they witnessed an improvement in their client that day or when they witnessed the "aha!" moment on their client's face.

Blough often advises clients to journal or otherwise reflect on these positive experiences before they go to bed because it can help prevent rumination and intrusive thoughts that may disrupt sleep. Celebrating these "little victories" will help renew their passion for their job, she adds.

As Blough points out, "Empathy can definitely lead to compassion fatigue, but if properly managed, it can also foster compassion satisfaction, which is the antithesis of compassion fatigue. It's the joy you get from your work." ❖

Lindsey Phillips is a contributing writer to *Counseling Today* and a UX content strategist. Contact her at *hello@lindseynphillips.com* or through her website at *lindseynphillips.com*.

Revisiting 20/20: A Vision for the Future of Counseling

Counseling leaders involved in the strategic planning initiative that launched in 2005 reflect on how the multiyear endeavor helped to forge consensus and moved the profession forward

By Bethany Bray

In the world of ophthalmology, having 20/20 vision means that a person can see the letters on an eye chart clearly and sharply while standing 20 feet away. It is estimated that just 35% of adults have 20/20 vision without the help of glasses or other corrective aids.

Fifteen years ago, leaders from a wide range of counseling organizations embarked on an initiative to bring the profession and its future into sharper focus. Those leaders, representing 31 counseling organizations, met regularly between 2005 and 2013 to identify and forge a vision for the direction the profession of counseling should be heading — into the year 2020 and beyond. The initiative, co-sponsored by the American Counseling Association and the American Association of State Counseling Boards (AASCB), was ultimately named 20/20: A Vision for the Future of Counseling.

What organizers initially intended to be a two-year endeavor stretched into eight years. Not surprisingly, the participants weren't always in agreement, but simply having delegates from 30-plus counseling organizations — representing a broad range of specialty focuses and passions — in the same room was a watershed moment for the profession.

"The adage about herding cats applies here, but these cats were all dedicated professionals passionate about consensus building; seemingly disparate cats whose visions would contribute immeasurably to the establishment of a unified profession," says Kurt L. Kraus, who facilitated 20/20 in the latter years of the initiative, succeeding Samuel T. Gladding, a past president of ACA.

"Prior to the work of the 20/20 [initiative], I believe that all of our partner organizations had worked tirelessly to establish themselves as free-standing and supporting pillars in a warehouse of counseling and related fields. But the project asked delegates and their organizations to look at the house as a whole," Kraus says. "It was time in our evolution to answer the question of *are we a profession*? And the answer was a resounding 'yes.'"

Steps toward unity

The 20/20 initiative was born out of a conversation focused on the future of the counseling profession that leaders from ACA and AASCB had over breakfast at ACA's 2005 Conference & Expo in Atlanta. The group, which included the presidents, presidents-elect and presidents-elect-elect of both ACA and AASCB, in addition to David Kaplan, then ACA's chief professional officer, eventually was established as the oversight committee for the initiative.

Kaplan recalls Gladding and Kraus as "world-class" facilitators who "knew just when to comfort the afflicted and afflict the comfortable." Kaplan also gives credit to Gladding for coming up with the 20/20 title for the initiative.

The initiative got into full swing at the ACA 2006 Conference & Expo in Montréal. Gladding brought the first full meeting to order with delegates attending from each of the participating organizations. Lynn Linde, who is today ACA's chief knowledge and learning officer, remembers the energy and buzz that filled the room as delegates took their seats.

"There was a sense of excitement that we were doing something historic — and confusion on how we were going to get there. … It was overwhelming but also exciting. The counseling profession had needed this, [had] talked about this, for a long time," recalls Linde, who initially served as a 20/20 delegate for ACA's Southern Region before joining the oversight committee as ACA president-elect and ACA president (2009-2010).

Across years of work and countless hours of discussion, the 20/20 initiative yielded several major accomplishments, the first of which was a document titled *Principles for Unifying and Strengthening the Profession*.

Created and unanimously approved by the delegates as the project's first milestone, the principles document identified seven critical areas that needed attention from the counseling profession:

- Strengthening identity
- Presenting ourselves as one profession
- Improving public perception/recognition and advocating for professional issues
- Creating licensure portability
- Expanding and promoting the research base of professional counseling
- Focusing on students and prospective students
- Promoting client welfare and advocacy

When the delegates took the document back to their respective organizations, just one declined to endorse it: the American School Counselor Association (ASCA).

The creation and ratification of the principles document was historic, Kaplan says, because it marked the first time nearly all of the major stakeholders in the field recognized and acknowledged that they were part of one unified profession: the profession of counseling.

"Counseling organizations have tended to operate as a loose federation, with each tending to their specific focus. The *Principles for Unifying and Strengthening the Profession* was the first time in history that professional counseling's membership, training and certification organizations put in writing that they shared a common professional identity and are all part of a single profession," explains Kaplan, an ACA past president (2002-2003) who retired in 2019 after 15 years on staff at the association. "The *Principles for Unifying and Strengthening the Profession* acted as a catalyst for the change of status from ACA division to independent organization for both the American School Counselor Association and the American Mental Health Counselors Association (AMHCA). While the ASCA and AMHCA affiliation status change caused disruption … it was a healthy development for both the organizations and the counseling profession, as this was an acknowledgment of an evolution that had been occurring for many years."

Adds ACA President-Elect S. Kent Butler, who served as a 20/20 delegate for the Association for Multicultural Counseling and Development (AMCD), "It was important to go through [the 20/20 process] so that counselors could unify and find one voice that we all could champion and use to successfully push our profession forward. The takeaway for me is the bonding that occurred, though contentious at times, because we were in this mission together. Across the 31 organizations involved, I was also able to build strong professional relationships with many of the delegates."

Finding consensus

After participating organizations endorsed the 20/20 principles document, focused effort was put toward addressing two of the critical areas identified in the document: solidifying professional identity and forging a path toward licensure portability, or the ability for counselors to transfer their professional license when moving from one state to another.

One of the primary ways the delegates sought to strengthen professional identity was by developing a unified definition of counseling. The definition was meant to be an "elevator pitch," something succinct that would easily explain what counselors do to the public and to other helping professionals. Ultimately, the 20/20 delegates reached consensus in 2010 on a one-sentence statement: "Counseling is a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education and career goals."

"It was important that we define counseling and the principles on which it is built and not have outside groups try to define it for us," Gladding says. "It was also crucial to establish that although counseling is diverse, there is a common core. As Maya Angelou writes in her poem 'Human Family,' 'We are more alike, my friends, than we are unalike.'"

ACA Past President Bradley T. Erford counts creation of a consensus definition of counseling as being among the initiative's most meaningful achievements. "I am fond of saying that

it took 31 counseling professionals 24 months to agree on a 21-word definition of counseling. But we did," he says. "20/20 was a coming-of-age event in the counseling profession. We needed consensus on some of the most pressing issues of the day, including licensure requirements and professional identity."

Erford initially served for six years as a 20/20 delegate for the Association for Assessment and Research in Counseling (AARC) before moving onto the oversight committee when he became ACA president-elect and president (2012-2013).

Lack of portability has been a long-standing problem in the counseling profession, in large part because license requirements vary widely. License requirements for counselors were set up state by state over a period of decades — beginning with Virginia in 1976 and ending with California in 2009 — as the profession matured and pushed to establish itself. But in the process, significant disparities arose between counselor licenses across the United States, from the number of supervision hours required to obtain a license to the license titles themselves.

The 20/20 delegates hoped to spark movement toward license portability by developing and gaining support for a single overarching scope of practice for the profession and a single preferred license title. Both ideas emerged out of a subinitiative of 20/20 called the Building Blocks to Portability Project.

"We wanted to get to the heart of who are we as a profession, our professional identity. We spent hours locked in that room talking about this," Linde recalls. "Everyone was amazed that we got there, that we trusted the process and were actually able to [reach consensus]."

The 20/20 delegates finalized the consensus licensure title — choosing *licensed professional counselor* (LPC) — and scope of practice in March 2013. (Turn to page 39 for the full text of the 20/20 scope of practice, a five-paragraph job description that defines the work of professional counselors.) Both items were recommended for use to state licensing boards across the United States in a letter co-written by the leadership of ACA and AASCB and sent in the summer of 2015.

The 20/20 delegates also debated but ultimately weren't able to reach consensus on a third piece of the Building Blocks to Portability Project: uniform education requirements for licensure. Even so, as a whole, the 20/20 initiative stands as a large-scale success that moved the counseling profession forward and made it much better prepared to meet subsequent challenges.

"Until 20/20: A Vision for the Future of Counseling, we allowed external forces to define what we could do," Kaplan says. "Apart from the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the Council on Rehabilitation Education (CORE) training standards, this was the first time in history that the counseling profession told the world what our skill set is. As with the consensus licensure title, having one scope of practice promoted by professional counseling to licensure boards helps solidify counselor identity, leads to licensure portability, reduces confusion among the public, and facilitates needed legislation. [This initiative] was the mark of a profession that had reached maturity. Until 20/20, the counseling profession had focused on being reactive and responding to how others defined us — particularly psychology. … [The 20/20 initiative] was the first time in history that all of the two-dozen-plus stakeholders within counseling worked together for a sustained period of time to develop a road map for the advancement of our profession."

Find out more

Additional details about the 20/20 initiative, its participants and accomplishments are available on the ACA website at *tinyurl.com/2020InitiativeACA*.

In addition, the project generated three *Journal of Counseling & Development* articles (ACA members have electronic access):

- Summer 2011 issue: "A Vision for the Future of Counseling: The 20/20 Principles for Unifying and Strengthening the Profession," by David M. Kaplan & Samuel T. Gladding
- July 2014 issue: "20/20: A Vision for the Future of Counseling: The New Consensus Definition of Counseling," by David M. Kaplan, Vilia M. Tarvydas & Samuel T. Gladding
- April 2018 issue: "Building Blocks to Portability: Culmination of the 20/20 Initiative," David M. Kaplan & Kurt L. Kraus

A lasting legacy

In January 2019, ACA signed a contract with the Council of State Governments' National Center for Interstate Compacts, embarking on a multiyear project to develop an interstate compact focused on counselor licensure portability. The project is still in the early stages, but its ultimate goal is to create a compact that states could adopt to accept the credentials of professional counselors who are licensed in another state. Individual state licensing boards would be allowed to impose additional requirements such as a jurisprudence exam or an FBI background check, but the compact could keep counselors from having to apply for a new license — in some cases, starting over virtually from scratch — when they move across state lines.

Getting this project off the ground has been made easier by the foundation built by the 20/20 initiative, says Linde, who serves as ACA's staff liaison to the interstate compact for portability project. She notes that the cohort is using LPC, the 20/20 consensus licensure title, in its work.

"The 20/20 project made it much easier for the compact project to come to an agreement on who we are and what we do. We didn't have to rehash years of work. It made it easier to get started and look at other issues around portability," Linde says.

Kaplan agrees, saying that the 20/20 initiative "provided both background and energy for ACA's national interstate compact project. Many ACA Governing Council members referenced 20/20 when

they approved the substantial amount of money needed to fund this project. If all goes as planned, the interstate compact will go a long way toward solving both our long-standing licensure portability and cybercounseling [telebehavioral health] problems."

(For more details about the compact project, search for the article "Interstate compact plan provides hope for licensure portability" at *ct.counseling.org*.)

20/20: In their own words

Counseling Today reached out to some of those who participated in 20/20: A Vision for the Future of Counseling to reflect on the lasting impact of the initiative.

Now that the 20/20 initiative is in the rearview mirror, what reflections would you like to share?

"The elegant premise that change begets change is so visible when we look back at where we were to where we now are. … I remember approaching my role as facilitator — not to mention how daunting that role felt following Sam Gladding *and* being asked by the oversight committee to bring this 'two-year project' to conclusion before we actually reached 2020 — as that of an orchestra conductor. The 30-plus people gathered together were each soloists, and my task was to help them coalesce into an ensemble — an apt analogy for the mission of the project actually.

"The delegates had to see themselves as a cohesive group who could practice together only briefly before the individual members would travel back to their home symphonies to play. Home, they then had to present this vision for the future of counseling to their organizations/affiliations in order to garner 90% agreement [the majority needed for consensus approval during 20/20] and adoption. Conducting was an honor for me." **— Kurt L. Kraus, LPC, 20/20 facilitator and professor and director of the doctoral program in the Department of Counseling at Shippensburg University of Pennsylvania**

Thirty-one counseling organizations participated in the 20/20 initiative. This photo, courtesy of Samuel T. Gladding (kneeling at center), shows some of the delegates and other stakeholders who took part in the first full meeting in 2006 in Montréal during the ACA Conference.

"I'd like to emphasize that everybody — all 31 organizations — had the ability to be heard, and every voice carried weight. No one voice was more important than somebody else's.

"Sometimes I see the [20/20] definition of counseling on someone's email signature, and it makes me feel that we really did make an impact. It's in textbooks, and we have a whole group of counselors out there who were trained using this definition. I have had those elevator speeches with people. It's nice to have some prepackaged words to be able to answer the question, 'What do you do?'" **— Lynn Linde, past president of ACA and current chief knowledge and learning officer**

Why was it important to go through the process of 20/20?

"In some instances, our profession was being left out of important legislative initiatives, insurance reimbursements and recognition of the efficacy of counseling due to our fragmentation as a profession. Bringing together all the players [the 31 participating organizations] allowed us to begin to speak with one voice to the public and government. More than this, it allowed us to break down fences between us and make the connections necessary to value each other's contributions to the profession." **— Perry C. Francis, LPC, 20/20 delegate for the American College Counseling Association and professor and counseling training clinic coordinator at Eastern Michigan University**

Now that we're in the year 2020, do you feel the project hit the mark?

"Yes and no. Yes: We are seeing the fruits of our labor begin to take root as licensure laws are rewritten, cooperation between organizations increases, and the counseling profession is expanding into previously denied territory. CACREP and CORE eventually merged in part due to the 20/20 process.

"No: What I hoped would be quicker progress and greater unity has not come to fruition. For example, we are still fighting for reimbursement with Medicare, and the process of getting counselors hired into the U.S. Department of Veterans Affairs systems is painfully slow. By the time we got to the end of the 20/20 process, many of the leaders moved on to other issues, and the momentum lessened." **— Perry C. Francis**

"We completed the tasks that were possible to complete at the time. I was proud of our decision to end the project when we did because the work truly didn't end then. Like a therapeutic goal that can't fully be assessed as met,

or unmet, from in the office, we had to let go, be patient and watch to see how the vision of the profession of counseling would be operationalized, to fully emerge in real time. In 2020, I have smiled every time I read some reference to the work done by everyone involved in the project. It was a cast of hundreds.

"The results are visible, the references to our work are plentiful, and the process resulted in a host of next steps. Inherent in the evolution of a profession is change — the work left undone arises from the work accomplished. As our profession is rooted in humanity and all of its complexities, it is probably safe to say our work will always be undone." **— Kurt L. Kraus**

What do you feel was accomplished by the 20/20: A Vision for the Future of Counseling initiative?

"We have had several positive things happen during the last few years. First and foremost, all 50 states now have [counselor] licensure, the last one being California. Another advancement was the communication between states. There were times when states did not communicate with each other. Some states were more exclusive rather than inclusive. Now, there seems to be more acceptance between states.

"Another accomplishment is the uniformity of state requirements. More states are complying with the stricter requirements, such as requiring 60 hours in a degree program. … As one person put it, [prior to 20/20,] going from state to state was more like going from one country to another." **— Charles Gagnon, an LPC and supervisor, member of the 20/20 Oversight Committee and AASCB past president**

"The project brought counseling groups together in a way that was nonpolitical and altruistic. We were all working for the good of the profession in what it could be. There were some disagreements, but there was [also] a lot of harmony, and when delegates were not together on a point, they worked constructively to reach consensus. I have never been in a better group in my life. It was a lot of hard work, but it was worth it.

"I wish we could have accomplished more, but given that we met in person only once a year, we did well, and the profession of counseling is better and stronger, I believe, for 20/20.

"20/20 was a proactive project. Too often, counseling has been reactive. 20/20 changed the mindset and made efficacy even more important professionally. I think the spillover from 20/20 continues." **— Samuel T. Gladding, 20/20 facilitator, ACA past president and a professor of counseling at Wake Forest University**

"The project has yielded many things. For one, the consensus definition for counseling, which has helped in our quest to unify our profession. I believe that the project was also a slowly evolving start to conversations surrounding inclusion. This may have been undergirded in our conversations about unifying the profession.

"While it is many years later, [it is] funny how in 2020 we are able to engage in conversations that actually matter as they relate to unity. I stated in the past that there was quite possibly a breakthrough in which it seemed we 'gave ourselves permission to engage in enriching conversations that will further unify our counseling community.' I was able to chair a task force a couple of years back that provided a template for engaging in difficult dialogues. Amazingly, the current pandemic has forced our hand,

Remembering J. Barry Mascari

Any mention of the 20/20 initiative would be remiss without acknowledging the important contributions of J. Barry Mascari, who passed away in May at age 71. Mascari was a part of the initiative from its start in 2005, participating in initial discussions and planning sessions as AASCB president-elect-elect. He remained closely involved throughout the entirety of the 20/20 initiative.

"Barry will always be known as the father of 20/20: A Vision for the Future of Counseling," says David Kaplan, ACA staff administrative coordinator for 20/20. "It was his brainchild, and he willed it into existence. Barry is greatly missed, but his legacy in catalyzing the growth of the counseling profession continues on."

At the time of Mascari's passing, ACA CEO Richard Yep acknowledged how instrumental he had been to the 20/20 project, as well as to numerous other advances in the profession, including co-authoring the counselor licensure law in New Jersey.

"His [Mascari's] tireless work to advance licensure portability, mentor his students, and advocate on behalf of the profession was in part what led to his 2019 selection as an ACA Fellow," Yep said.

Mascari, a licensed professional counselor and counselor educator at Kean University in Union, New Jersey, was co-author with his wife, Jane M. Webber, of the book *Disaster Mental Health Counseling: A Guide to Preparing and Responding*, published by the ACA Foundation.

and we are courageously engaging in that process now.

"Lastly, while we are not where we want to be in the battle for portability, we are strategically making progress in bringing this concept to fruition with our pursuance of an interstate compact. The vision gave us flexibility perhaps to find alternative ways to support counselors seeking to move or start a practice in another state." **— S. Kent Butler, ACA president-elect, 20/20 delegate for AMCD, and interim chief equity, inclusion and diversity officer and a professor of counselor education at the University of Central Florida**

What work is left undone?

"The only thing on which 90% consensus was not reached [during 20/20] was educational requirements because CACREP and CORE had not yet merged. If we had extended the task force two more years, I believe adoption of the CACREP standards would have passed by consensus.

"There are many additional counseling issues that have been percolating under the surface for a number of years that a new multiorganizational task force should tackle. And many of these issues are international in scope. I suggested creation of a multinational task group [while I was ACA president] to address international counseling issues and priorities, [but it] never got prioritized." **— Bradley T. Erford, ACA past president, 20/20 delegate for AARC and member of the 20/20 Oversight Committee; director and professor in the counseling program at Peabody College at Vanderbilt University**

"The profession of counseling is always changing, and so there is more to be done. Certainly, getting counselors to be considered core mental health providers and reimbursed by the military, the government and insurance companies is a next and continuous major step." **— Samuel T. Gladding**

20/20 Scope of Practice for Professional Counseling

The independent practice of counseling encompasses the provision of professional counseling services to individuals, groups, families, couples and organizations through the application of accepted and established mental health counseling principles, methods, procedures and ethics.

Counseling promotes mental health wellness, which includes the achievement of social, career and emotional development across the life span, as well as preventing and treating mental disorders and providing crisis intervention.

Counseling includes, but is not limited to, psychotherapy, diagnosis, evaluation; administration of assessments, tests and appraisals; referral; and the establishment of counseling plans for the treatment of individuals, couples, groups and families with emotional, mental, addiction and physical disorders.

Counseling encompasses consultation and program evaluation, program administration within and to schools and organizations, and training and supervision of interns, trainees and pre-licensed professional counselors through accepted and established principles, methods, procedures and ethics of counselor supervision.

The practice of counseling does not include functions or practices that are not within the professional's training or education.

What's next? Do you think the counseling profession should begin some kind of new strategic planning project to continue this work?

"One idea that has been tossed around for future strategic planning is in the area of focusing on prospective students [one of the seven points in the *Principles for Unifying and Strengthening the Profession*]: developing an undergraduate major in counseling. Unlike other helping professions such as psychology and social work, professional counseling does not have any feeder programs. As a result, our students find us by happenstance. Many undergraduates who would thoroughly enjoy a career in professional counseling and would greatly benefit the clients they serve never hear about our programs. Exactly what an undergraduate major in counseling looks like and how it is implemented is for a future planning process that focuses on the counseling profession in 2030 and beyond." **— David Kaplan, 20/20 administrative coordinator and retired ACA chief professional officer**

"I believe the profession needs to really embrace the momentum that has begun around dismantling systemic racism. To be true to our code of ethics, we must consciously and consistently make sure that professional counselors do no harm. A very important addition to our next go-around at strategic planning needs to be deliberate attempts to make our profession more inclusive, especially within every level of leadership across every ACA entity.

"Each of us is accountable and should be beacons for our students and colleagues, ensuring that they are adequately trained and/or held accountable for the work that they do with their clients. … We also must be accountable to society and work to break down barriers that prevent equity for all." **— S. Kent Butler** ❖

Bethany Bray is a senior writer and social media coordinator for *Counseling Today*. Contact her at *bbray@counseling.org*.

Opinion

Unmasking White supremacy and racism in the counseling profession

If counselors are truly committed to advancing diversity, equity and inclusion, it is time to challenge the status quo rather than remain silently complicit

By Patricia Arredondo, Michael D'Andrea & Courtland Lee

Our country has been roiling through two major pandemics. The first, COVID-19, is still relatively new, and with a vaccine, the incidences of this miserable disease should decrease and diminish over time. In contrast, the pandemic of White racism and White supremacy has long been at the heart of the persistent psychological, emotional and behavioral racial tensions and injustices that we face in the United States. The senseless killing of George Floyd and other Black citizens has raised awareness once again of the violence of White racism and police brutality in many sectors of society.

The National Institute of Mental Health recently published a report indicating that between 17 million and 22 million adults in the United States are in need of professional mental health services each year. It was further determined that only 41% of these individuals receive such services. The fact that a majority of adults in need of mental health services do not receive this important care represents an ongoing health care crisis in our country. And, of course, COVID-19 stressors are only compounding mental health distress.

When researchers focused on the racial disparities linked to this pandemic, those from African, Asian,

> Little has substantially changed over the past 50 years. Multicultural counseling is still a one-semester course. Theories of counseling, career development and human development are Eurocentric and dated.

Latinx and Indigenous backgrounds were found to be substantially overrepresented among those adults not receiving or not having access to mental health care. This finding reflects what supporters of the Black Lives Matter movement and many social justice advocates in general are talking about when they point to disparities resulting from systemic racism and White privilege in this country.

Institutional racism in the profession

In 1982, nearly 40 years ago, Derald Wing Sue wrote, "Counseling is the handmaiden of the status quo." This phrase relates to the ways that many counselor educators, practitioners, supervisors and students are inextricably linked to perpetuating White racism and White supremacy by remaining silent, noncommittal and inactive in the face of so many forms of structural and institutional racism.

Sadly, this situation is still a reality as unintentional and covert forms of racial injustice continue to be manifested in counselor training, research and practice. For example, how prepared are counseling students to work with those who speak English as a second language, those who are recipients under the Deferred Action for Childhood Arrivals program, families in poverty and so forth? When are counselor training programs requiring community service to link to social justice principles and competencies endorsed by the American Counseling Association? How do counselor training programs prepare students to talk about racism with clients? If counselor educators and counseling programs were to take on these three queries, they would find opportunities to unmask racism and decrease their behavior as a "handmaiden of the status quo."

Professionals and students alike must commit themselves to move toward bold, courageous and morally grounded actions. We must go beyond our favorite mode of operating, which often involves the overuse of intellectual analysis of these social pathologies. As we critically analyze the mental health impacts of these injustices on our clients' lives, let us be reminded that Martin Luther King Jr. warned us that an overemphasis on such intellectualization without substantial social justice actions too often results in the *paralysis of analysis.*

Challenging the counseling status quo

In 1992, Michael D'Andrea, one of the co-authors of this article, wrote a column in *Counseling Today* (then named *The Guidepost*) titled "The violence of our silence: Some thoughts about racism, counseling and human development." In that column, he asserted that if they continued to operate as witnesses and bystanders to various forms of institutional, societal and cultural racism, counseling professionals and students would become guilty of being racists themselves through their silent complicity.

Some progress has been made as a result of a minority of counselor educators, practitioners, supervisors and students taking courageous action to boldly and routinely describe the ways that White supremacy and White racism adversely affect the counseling profession and the racially diverse clients we serve. However, it is apparent that much more needs to be done in these areas. Today, there are education and training programs guiding professionals in moving away from bystander behavior and toward action. The #EquityFlattensTheCurve initiative is offering a Bystander Anti-Racism Project.

Identifying areas of urgency in the counseling profession is also part of unmasking racism. Just take note of the contemporary counseling profession. In doing so, you are likely to see the following: counselor educators, graduate students, supervisors in counseling centers, textbook authors, the theories studied, the research methodology applied in studies, CACREP site visitors, and the leadership in ACA, the Association for Counselor Education and Supervision and other professional associations all seeming to have a homogeneous identity.

Little has substantially changed over the past 50 years. A majority of White counseling students continues to be taught by a majority of White professors. Multicultural counseling is still a one-semester course. Theories of counseling, career development and human development are Eurocentric in nature and dated. Furthermore, counseling research has not advanced knowledge about racism, White

supremacy and the well-being of people of color. Samples of convenience continue to be normative, with many research participants coming from White, Western European, English-speaking and often Christian backgrounds.

All of this leads us to assert that the counseling profession has stagnated. This perpetuation of persistent Eurocentric conformity will soon be irrelevant and contribute to greater inequities in the preparation of counselors and the delivery of mental health care. This professional irrelevance will occur as a result of the unprecedented demographic transformation occurring in our nation. As one example, in 2013, for the first time, the percentage of Latinx high school graduates going on to college was higher than that of any other group, as reported by the Hispanic Research Center, and this representation in colleges continues. How many counselors are aware of this demographic shift?

Moving to action: Applying the MCCs

In 2003, the ACA Governing Council approved the Multicultural Counseling Competencies (MCC), originally published in 1992 by Derald Wing Sue, Patricia Arredondo (one of the co-authors of this article) and Roderick McDavis. The *awareness, knowledge and skills* paradigm remains as vital today as it was in 1992 when the MCC were published and in 1964 when the Civil Rights Act was passed. The MCC, the subsequent document on operationalization of the competencies that promotes intersecting identities in sociohistorical contexts (1996), and the Multicultural and Social Justice Counseling Competencies (2015) remain anchors to lean on during these times for needed change, increased awareness, more expansive knowledge and bold actions in the counseling profession. The 1992 competencies addressing racism are cited here for further application.

- Culturally competent counselors possess knowledge and understand about how oppression, racism, discrimination and stereotyping affect them personally and in their work. This allows them to acknowledge their own racist attitudes, beliefs and feelings. Although this standard applies to all groups, for White counselors it may mean that they understand how they may have directly or indirectly benefited from *individual, institutional and cultural racism*.
- Culturally competent counselors are constantly seeking to understand themselves as racial-cultural beings and actively strive to develop a nonracist identity.
- Culturally competent counselors are knowledgeable of *sociopolitical influences* that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping and powerlessness all leave major scars that may influence the counseling process.
- Culturally competent counselors become actively involved with [ethnic/racial] minority individuals outside the counseling setting (via community events, social and *political functions*, celebrations, friendships, neighborhood groups and so forth) so that their perspective of minorities is more than an academic or helping exercise.
- Culturally competent counselors strive to eliminate biases, prejudices and discriminatory practices. They should be cognizant of clients' *sociopolitical contexts* when conducting evaluations and providing interventions. They also continually attempt to develop greater sensitivity to issues of oppression, sexism and racism especially as they affect their clients' lives.

Racial reckoning: If not now, when?

The country has entered a period of racial reckoning. New incidents of racism and anti-Black behavior are reported on a daily basis on city streets, on college campuses and in stores. The challenge to not be bystanders persists, and as counselors committed to advancing diversity, equity and inclusion, we must be activists and advocates for social justice. We must rise to the task of unmasking White supremacy and White racism in both our professional training and practice as professional counselors.

We need to ask ourselves, if not now, when will we take these actions? If not us, who will make the changes to have the counseling profession move beyond the "violence of our silence" and the role many educators, supervisors and students play as "handmaidens of the status quo"? ❖

Patricia Arredondo is a past president of the American Counseling Association and the Association for Multicultural Counseling and Development and a founding member of Counselors for Social Justice. She partners with organizations to address diversity, equity and inclusion initiatives through the Arredondo Advisory Group. Contact her at *parredondo@arredondoadvisorygroup.com*.

Michael D'Andrea is an associate professor at Springfield College in Springfield, Massachusetts. He is one of the founders of Counselors for Social Justice. Contact him at *michaeldandrea1@gmail.com*.

Courtland Lee is a past president of the American Counseling Association and the Association for Multicultural Counseling and Development. He is a professor in the counselor education program at the Washington, D.C. campus of the Chicago School of Professional Psychology. Contact him at *clee@thechicagoschool.edu*.

A beginner's guide to client confabulation

Confabulation has the potential to compromise screening, assessment and treatment planning, making it a crucial clinical phenomenon for mental health professionals to understand and address in practice

By Jerrod Brown & Megan N. Carter

In the context of mental health treatment, client confabulation refers to the unintentional recollection and formation of false memories, ranging from subtle embellishments to grandiose elaborations. Confabulation may take the form of a true memory being inserted into an incorrect temporal, spatial or event context. In other words, confabulated memories can be based on an actual memory taken out of temporal context, or they can result from the creation of a completely fabricated memory (one not based on a previously held belief, experienced event or memory). Confabulation may also involve the incorporation of confabulated details or events as part of a true memory.

It is important for mental health professionals to remember that people who confabulate are unaware that they are engaging in this memory phenomenon and have no intent to deceive. Clients who confabulate have no conscious awareness that their memory is false; in fact, they often strongly believe that their memory is true. Confabulation can also manifest in verbal or behavioral displays of unintentional dishonesty.

Confabulation is distinct from delusions, which are firmly held false beliefs that follow a consistent theme and result from psychosis, often involving an alteration of lifestyle to accommodate the false beliefs. It is also distinct from malingering, the purposeful deviation from the truth to achieve a desired outcome (e.g.,

reporting mental health symptoms that are not present to receive disability payments). Although confabulations and delusions may share a common pathophysiology (i.e., they can present similarly), they are separate phenomena.

Confabulation is a complex and confusing topic with an uncertain etiology, and it remains under-investigated within the context of mental health treatment. It is loosely associated with a number of neurobehavioral/neurodevelopmental disorders (e.g., fetal alcohol spectrum disorder [FASD], intellectual disability) and neuropsychiatric (e.g., schizophrenia), neurocognitive (e.g., dementia, traumatic brain injury) and medical health conditions (e.g., Korsakoff's syndrome, various brain diseases). Adding to this confusion is the fact that confabulation can also occur among individuals with no identified impairments, disorders or diseases when certain factors are present (e.g., memory confusion, an attempt to fill in a memory gap, high-pressure and stressful interviews).

Although the underlying brain processes associated with confabulation are currently unknown, possible causes have been suggested in the research literature. These include:

- Attempt to preserve self-coherence
- Attempt at self-enhancement
- Competing memories varying in strength and emotional significance
- Executive functioning deficits
- Fast-paced and stressful interviewing approaches
- Frontal lobe dysfunction
- Guided imagery
- Hypnosis
- Impaired attentional control
- Impulsivity
- Memory encoding and retrieval deficits
- Memory loss
- The mistaking of imagined events for real ones
- Overconfidence
- Attempt to preserve a sense of self-identity and self-esteem
- Reality-monitoring deficits
- Repeated lines of questioning
- Self-monitoring deficits
- An eagerness to please (i.e., wants to demonstrate an ability to answer all the questions)

Most commonly observed in the retrieval of autobiographical memories, confabulations can include information inspired by peers, television, movies and social media. Inspirations for confabulation may also occur from overhearing conversations from other individuals (e.g., inpatient treatment settings, group treatment programs, sober support meetings).

Mental health professionals are often unaware of this topic and typically receive little to no training in the implications of confabulation on client populations. Because of its potential to compromise screening, assessment, treatment efforts, discharge planning and placement, confabulation is a crucial clinical phenomenon for mental health professionals to understand and address in practice.

Types of confabulation

There are two principal forms of confabulation: provoked and spontaneous. Provoked confabulations are incorrect responses to questions or situations in which a person feels compelled to respond. Examples of such situations include intake assessments, investigative interviews and testifying in court.

Research has established that the more stressful a situation is perceived to be, the more likely confabulation is to occur. This is why mental health professionals working in criminal justice or forensic mental health settings need to pay particular attention to a patient's possibility of confabulation, which may lead to inaccurate diagnosis or symptom identification. Additionally, unintentionally misremembered information can derail the legal process if the person provides inaccurate eyewitness information, prematurely waives Miranda rights, provides false confessions to police or enters inaccurate testimony in court. In the worst-case scenario, it could even result in wrongful convictions.

Spontaneous confabulations are not linked to a particular cue. They range from misremembering insignificant information to generating fantastic and grandiose details. They are believed to result from a reality-monitoring deficit in the frontal lobe combined with organic amnesia. Spontaneous confabulations also differ from provoked confabulations in that most patients eventually stop engaging in the behavior.

Provoked and spontaneous confabulations can be expressed either verbally or through behavior. Verbal confabulation involves articulating a false memory, whereas behavioral confabulation involves acting on a false memory (e.g., going to the wrong home because the person believes it is where they live). Regardless of the form they take, false memories can evoke real emotions from clients, who may have a high level of confidence in the accuracy of their recall despite evidence to the contrary.

An example that one of us experienced occurred in the course of a forensic mental health interview with a woman who was subsequently diagnosed with Korsakoff's syndrome. During the course of the evaluation, it was clear that she had significant difficulty developing new memories but was able to recall long-term historical memories (e.g., childhood autobiographical memories). She described recently babysitting a neighbor's three preschool-age children, including fixing them snacks and letting them watch television. A report was made to child protective services because of the woman's significant impairments and concerns about the safety of the young children in her care. A subsequent investigation concluded that the woman had not been left to babysit the neighbor's young children; this was an apparently confabulated memory.

Screening and treatment

There are various theoretical models to explain confabulation. One implies a failure to suppress memory traces that were used in the past but that are no longer relevant to what the person is

currently trying to remember. Another theory posits that the person simply failed to retrieve the relevant memory. Finally, another theory is that the person failed to locate the memory for that time and context and essentially inserted another memory in its place.

Numerous conditions can increase the likelihood of confabulation, including:

- Dementia
- Encephalitis
- FASD
- Frontal lobe tumors
- Frontotemporal dementia
- Herpes simplex encephalitis
- Learning disabilities
- Nicotinic acid deficiency
- Korsakoff's syndrome
- Multiple sclerosis
- Schizophrenia
- Subarachnoid hemorrhage
- Traumatic brain injury

Given that confabulation has an unclear etiology, multiple definitions, and statistical and clinical associations with a range of neurobehavioral, neurodevelopmental, neurocognitive and neuropsychiatric conditions, the use of a valid and reliable screening procedure is essential. This will help mental health professionals avoid inaccurate diagnoses and the development of ineffective treatment plans that could exacerbate underlying conditions. Screening areas for consideration during confabulation evaluations include:

- Abstract and sequential thinking
- Attention-deficit/hyperactivity disorder
- Executive functioning
- History of trauma
- Sleep
- Learning capabilities
- Social skills
- Memory
- Receptive and expressive language
- Sensory processing
- Source monitoring
- Suggestibility
- Prenatal alcohol exposure

While confabulation can occur for a variety of reasons, early identification, support and monitoring are key. Possible screening tools that may be useful include the Nijmegen-Venray Confabulation List and the Confabulation Screen. Use of these tools may provide a beginning analysis for further exploration of this issue. If confabulation occurs but is thought to be due to an organic condition such as Alzheimer's disease, dementia or FASD, referral for neurological testing is appropriate and can provide insight into which areas of the brain are most affected. This can assist in determining the best treatment approach given the individual's particular areas of need.

Regarding treatment, specific intervention strategies have been found to be useful with clients or patients who confabulate. These strategies involve:

- Avoiding confrontation
- Avoiding leading questions
- Avoiding sensory overload
- Avoiding closed-ended questions
- Using a slow-paced interview format
- Using collateral sources to confirm self-report
- Using developmentally appropriate language
- Reassuring that it is acceptable not to know an answer
- Checking for comprehension
- Minimizing stress
- Providing family/support-person education
- Allowing for extra processing time
- Allowing for long pauses and silence
- Treating underlying mental health conditions
- Treating underlying physiological conditions
- Teaching memory diary use
- Teaching reality-monitoring techniques
- Teaching self-monitoring techniques

Establishing a therapeutic relationship with such clients requires acknowledgment that their misremembering is not intentional and that it lacks malice. This can be challenging for clinicians for several reasons: countertransference, frustration at not knowing whether a client's documented previous diagnoses or symptoms are accurate, and an unconscious bias that assumes the recollection of inaccurate memories is the result of the client trying to gain something else (i.e., malingering) such as money or attempting to get out of trouble.

Clinicians should avoid minimizing what the client is reporting or prematurely assuming that the client is deliberately being noncompliant. In fact, clinicians should recognize that the content of confabulations may even provide useful information regarding the client's perceptions and behavioral approaches. Additionally, as previously mentioned, the confabulated information may result in real emotions for the client that will need to be acknowledged and processed.

Clinicians must be sensitive to the fact that individuals who confabulate may inadvertently thwart treatment efforts because they lack recognition that their recalled memories are false. To both address this lack of insight and ensure the collection of valid and reliable assessments, clinicians should obtain collateral information to support or refute a client's claims (especially when a false recollection could result in significant consequences). When clear evidence of confabulation is found, clinicians should appropriately document this in the client's case file and consider this during the entire treatment process (e.g., intake, screening, treatment planning, discharge planning).

Adaptive functioning

Confabulation can affect a person's ability to take care of oneself (e.g., personal hygiene, dressing, cooking), carry out activities of daily living (e.g., home cleaning, clothing care, financial management), and effectively maintain a social life (e.g., empathizing, reading nonverbal behavior, establishing a social group, engaging in effective communication). These adaptive functioning deficits can also lead to issues with filing forms to obtain

government services (e.g., disability benefits, subsidized housing) and gaining access to medical records to ensure high-quality continuity of care, as well as an increased vulnerability to victimization. Hence, those who chronically confabulate may be less likely to be able to live independently and more likely to require a high level of support.

Therefore, clinicians working with individuals who confabulate should consider administering a "gold standard" adaptive behavior inventory to help guide and inform treatment planning. Among these inventories are the Scales of Independent Behavior-Revised, the Vineland Adaptive Behavior Scales Third Edition and the Diagnostic Adaptive Behavior Scale. Similarly, clinicians working with clients who exhibit significant deficits in adaptive functioning, particularly in higher-level skills such as money management, should be alert to possible confabulations.

Although using a standardized assessment to evaluate adaptive skills can be useful in treatment assessment and planning, clinicians should also be aware of certain disorders, such as FASD, in which confabulation may be common and in which standardized testing does not necessarily identify deficits. For example, those with FASD may be able to complete tasks of daily living such as grocery shopping or managing personal hygiene, but they may have poor judgment (and social judgment in particular) that is not measured on typical adaptive functioning scales. For instance, they may be tricked out of money by someone who is "friendly" to them and then have difficulty understanding or explaining the missing money, so they engage in confabulation to account for it.

In such instances, in addition to using standardized testing, clinicians should carefully assess using qualitative analysis of abilities and interactions. This may be particularly important for those with FASD with regard to social skills or other areas of functioning that are difficult to measure. Confabulation may be demonstrated as a way to present a more functional ability with regard to a wide range of adaptive abilities and may need to be addressed through careful clinical interventions.

If adaptive behavior deficits are found, it is the responsibility of the administering clinician to educate the client's support systems (family, friends, education system) about the practical implications of these deficits. These support systems may need to be relied upon in cases of severe confabulation to ensure client safety and follow-through on the client's daily life affairs such as attending appointments and medication compliance. Unfortunately, strong support systems can be less common among this client population. Family, friends and teachers may feel distrustful of the confabulating individual because of a misperception that he or she is willfully attempting to deceive them. Clinicians play an important role in intervening in such misperceptions by educating clients' support systems on the unintentionality of the confabulations and explaining that they are the consequence of cognitive and neurological deficits.

Conclusion

Confabulation can be a serious obstacle in mental health professionals providing effective care and services. It can have a negative impact on intake, screening, assessment, treatment planning, medication/treatment compliance and discharge planning. For this reason, we urge clinicians to pursue self-study and continuing education training via in-person and online courses to expand their knowledge on this complex and multifaceted phenomenon. When a case of potential confabulation is identified, professionals should seek the guidance of recognized subject matter experts who routinely review key research findings on confabulation on at least a quarterly basis.

Finally, additional research is needed to continue establishing evidence-based screening and intervention procedures to identify individuals who may be at increased vulnerability for confabulation. Such screening procedures could be applied prior to clinical interviewing and in the treatment planning process to ensure that the information obtained is of higher fidelity. The use of such protocols would also familiarize users with the social and cognitive risk factors for confabulation, of which many mental health providers currently lack awareness. Through the adoption of such policies and procedures, the possible negative impact of confabulation can be minimized, appropriate intervention approaches can be implemented, and the likelihood of positive outcomes can be increased. ❖

Jerrod Brown is an assistant professor, program director and lead developer for the master's degree in human services with an emphasis in forensic behavioral health for Concordia University in St. Paul, Minnesota. He has also been employed with Pathways Counseling Center in St. Paul for the past 16 years. He is the founder and CEO of the American Institute for the Advancement of Forensic Studies and is editor-in-chief of *Forensic Scholars Today*. Contact him at *jerrod01234brown@live.com*.

Megan N. Carter is a board-certified forensic psychologist who practices in Washington state. Her career focus has been on forensic psychological evaluations in both civil and criminal court proceedings. She has also focused on providing education about fetal alcohol spectrum disorders to mental health professionals.

Self-injury: An overview for counselors

By building an understanding of the motivations for nonsuicidal self-injury, counselors can develop detailed plans that address clients' underlying issues

By Lauren Appel

The challenges that students face today can be complicated and overwhelming, causing some youth to resort to self-injury to cope with the stress. According to a study by Martin Monto, Nick McRee and Frank Deryck (published as "Nonsuicidal self-injury among a representative sample of US adolescents, 2015" in the *American Journal of Public Health*), 1 in 4 girls and 1 in 10 boys will self-harm.

From my experience as a school counselor, I have found that the presence of self-injury often indicates significant underlying emotional issues. Given these realities, I believe it is more important than ever for counselors to familiarize themselves with this dilemma. This overview is intended to walk through what self-injury is and isn't, who tends to be affected and how to intervene.

What is self-injury?

Self-injury, also known as nonsuicidal self-injury (NSSI), can be defined as deliberate, self-inflicted harm to body tissue without suicidal intent. This does not include behaviors that are socially accepted, such as piercings or tattoos. This definition is based on E. David Klonsky's research presented in "The functions of deliberate self-injury: A review of the evidence," published in *Clinical Psychology Review* in 2007.

NSSI includes, but is not limited to, cutting, burning, biting or scratching the skin, head banging, punching and pinching. Common injury sites include the hands, wrists, stomach and thighs, although injuries can occur anywhere on the body.

Who self-injures?

According to data taken from Jennifer Muehlenkamp and colleagues' 2012 study, "International prevalence of

> My past students who were victims of bullying or abuse often felt that they could not fight back. This led them to an internalizing coping mechanism, which resulted in self-injury.

adolescent non-suicidal self-injury and deliberate self-harm," published in the journal *Child and Adolescent Psychiatry and Mental Health*:

- 1.3% of children ages 5-10 self-injure
- 17% of adolescents self-injure (this figure is high because it includes those who have self-injured only once)
- 5% of adults self-injure

Overall, females have been reported to self-injure more than males. They tend to prefer cutting more than any other means of self-injury, according to Janis Whitlock and colleagues' 2011 study, "Nonsuicidal self-injury in a college population: General trends and sex differences," published in the *Journal of American College Health*.

Although males are reported to self-injure less often, it is possible that this is being underreported or that the self-injury is hidden behind behaviors deemed as "more masculine." For instance, males are more likely to deliberately bruise or cause abrasions to themselves by punching walls or instigating fights to have others hurt them.

This aligns with the incorrect perception that males have to demonstrate a certain caliber of "manliness" and that the only acceptable emotion for them to feel is anger. I have had male students who said they would be ridiculed as sissies if they expressed feeling sadness or pain or demonstrated other aspects of vulnerability. Males tend to get more "cool points" for behaviors such as picking fights or punching walls than for engaging in other types of self-harm such as cutting.

Whitlock et al. also discussed how LGBTQIA individuals are affected by self-injury. Those who identify as LGBTQIA self-injure more frequently than do their heterosexual counterparts. In particular, bisexual females were 6.2 times more likely to have engaged in self-injury at some point during their lifetime. These data showed that this subgroup is at the highest risk for NSSI out of the other populations studied in terms of gender and different types of sexual orientation. This is clearly a population at high risk that needs to be monitored.

I have found that individuals in this subgroup often self-injure because they feel split between what is expected of them and who they really are. They tend to carry a significant amount of self-blame for not meeting those expectations or feel frustrated for having what they believe to be disturbing thoughts. When their secret lives become consuming, they often turn to self-injury for "escape."

Trauma and bullying victims are also at high risk for self-injury according to Laurence Claes and colleagues' 2015 study, "Bullying and victimization, depressive mood, and non-suicidal self-injury in adolescents: The moderating role of parental support," published in the *Journal of Child and Family Studies*. Those who have experienced trauma can internalize the event, which causes emotions that are difficult to handle and makes them more susceptible to NSSI. Clients who frequently experience bullying or peer rejection also tend to self-injure more than their counterparts do. My past students who were victims of bullying or abuse often felt that they could not fight back; in other words, they did not externalize their behavior as a coping mechanism. This then led them to an internalizing coping mechanism, which resulted in self-injury.

Myths about self-injury

The following myths are inspired by a fact sheet on top misconceptions about self-injury produced by Saskya Caicedo and Janis Whitlock for the Cornell Research Program on Self-Injury and Recovery.

Self-injury is a suicide attempt or a failed suicide attempt. Research has shown that most people who self-injure do not have the intention to die by suicide. The main motivation for self-harm is to deal with emotional stress or pain. The category name of nonsuicidal self-injury in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* provides a sense of separation from suicidal intent. This category is also being used by other organizations and in research, thus creating a distinct line between self-injury and suicidal intent. The majority of my students who self-injure have expressed no interest in ending their lives; they were simply causing superficial injuries.

Self-injury is done to seek attention. Some individuals may use self-injury as a tool to seek attention, but it is important to realize that this action still represents a desperate cry for help. *Why are they going to such drastic lengths to get attention?* This is a question that we, as counselors, need to ask ourselves so that we can intervene accordingly. However, the majority of those who self-injure go to great effort to hide any evidence of cuts or scars. They tend to be secretive and have a difficult time discussing the underlying issues that plague them. Those who cut in secret demonstrate extreme emotional distress and need substantial help.

Anyone who self-injures is part of the Goth or emo subgroups. Research shows that self-injury is not limited to one specific group. Self-injury does not occur

on the basis of gender, socioeconomic status, sexual orientation, social group, race, profession or other categories. It is true that some groups are more affected than others by self-injury (as seen in previous demographics), but no group is completely excluded.

Someone who self-injures can quit if they really want to stop. Many experts in this area indicate that self-injury has the qualities of an addiction. The act of self-injury causes endorphins and other neurochemicals to be released in the brain, which essentially gives the person a type of "high." The chemicals eventually dissipate, and then a craving develops to experience that feeling again. This creates a cycle of addiction that makes it even harder to stop the behavior. Many individuals may need help and additional support to be able to stop self-injuring.

Although I have students who experiment with cutting and do it out of curiosity, there is a subgroup of students who chronically self-injure. They can't seem to "kick the habit," no matter how hard they try. Typically, this means that their underlying issues have yet to be resolved and that an adequate replacement coping mechanism needs to be put in place.

Someone who self-injures is a danger to others. Typically, those who self-injure are people who tend to internalize their emotional issues rather than externalize them. In other words, people who self-injure take their frustrations out on themselves rather than on others. This particular trait makes it highly unlikely that people who self-injure would harm someone other than themselves.

Why do people self-injure?

From my experience, there are a few main reasons that someone may self-injure. These do not, by any means, cover every possibility. In addition, some people may have multiple reasons that motivate their behavior to self-injure.

As a coping mechanism: Based on research findings, self-injury is a way to cope with emotional pain and distress that can stem from mental illness or trauma. These two issues typically involve internalizing behaviors, which is one of the factors in the personalities of those who self-injure. Those who self-injure lack healthy coping skills that allow them to function.

To feel or to numb: Especially in cases of depression, there can be physical symptoms such as numbness and emptiness. This disconnect with the body can cause individuals to self-injure for the sake of being able to *feel* something again.

On the opposite end of the spectrum, some people feel *too much.* This tends to occur in people who may have anxiety and are overwhelmed by emotions. Self-injury for these individuals is a form of distraction that places their focus on the injury rather than on the tidal wave of emotions engulfing them.

To self-punish: People who use self-injury for this reason tend to loathe themselves and to have extremely poor self-esteem. They often are perfectionists and will punish themselves for perceived academic, athletic or social failures. This is often where the high achievers are grouped: They expect nothing less than perfection from themselves, and they "pay for it" when they believe that they have fallen short.

Immediate interventions

The following are examples of immediate interventions that counselors can take with clients who engage in self-injury.

Screen for suicide. Although it has been established that the majority of self-injury cases do not involve suicidal intent, it is important in new cases to establish which category the action falls under: NSSI or preemptive attempt of suicide.

It is always a good idea to ask some screener questions such as "Have you thought about suicide?" and "Do you have a plan?" But avoid asking, "Do you think about hurting yourself?" It is obvious that the person is already *hurting* themselves, and if they answer that question affirmatively, then it is likely because they are engaging in NSSI versus trying to kill themselves. However, a misunderstanding about their answer could lead to a false positive of the person being suicidal. If the person does present as suicidal, then follow additional threat assessment guidelines.

Be aware of the need for medical attention. If the individual presents with fresh injuries, counselors should be alert to possible infections, the need for stitches or other medical issues that may arise. Often, people who self-injure cover up their cuts or injuries, and the trapped moisture can cause a bacterial yeast infection. With those who have created bruising, it is important to check for possible broken bones. This evaluation also creates an opportunity for counselors to explain the risk factors that accompany self-injury and how students or clients can protect themselves from medical crises.

Notify a family member or person of support. In these situations, it is necessary to inform the individual's parent, spouse or person of support. Self-harm is a sign of serious emotional distress, and the family needs to be made aware of what is happening so that they can be on the alert. It is also wise to talk with the person about removing any objects they could use to harm themselves, such as knives, scissors, push pins, lighters and so on. When first speaking with the student or client, try to collect information about which instruments they favor in inflicting self-harm so that there is a better idea of what objects need to be removed. Working with significant people in the client's life is key to ensuring the client's safety.

Supportive interventions

The following are examples of supportive interventions that counselors can use with clients who engage in self-injury.

Identify triggers. One of the best strategies for helping students or clients who engage in NSSI is to identify their triggers. Does it involve perceived failure? Does it involve feeling awkward? Does it involve rejection by peers? Once the triggers are named, the next step is to work with the student or

client to outline a plan for when these triggers arise. What alternative strategy can they use? What kind of self-talk will they employ? Do they need a break from the stressful activity? All of this needs to be planned and practiced.

Identify a network of trusted individuals. What I have learned on the basis of my students' experiences is that part of the method of operation for those who self-injure is to isolate. When students or clients do try to stop engaging in self-injury, they will need some sort of outlet for dealing with all of their complex emotions. Working with these students or clients to come up with a group of people they can trust is crucial to their recovery.

Find appropriate replacement behaviors. Odds are, the person has been using self-injury as a coping mechanism for a long time, and in order to recover, they will need to learn healthy coping strategies. Many people who struggle with self-injury are often high-sensory seeking, particularly with tactile sensory input. Replacing self-injury with fidget items that provide tactile feedback (cotton balls, string, erasers, textured stress balls, etc.) may offer more successful replacement behaviors.

Other methods of expression, such as drawing or writing, can also be beneficial because they provide an outlet for the person's anxieties. This makes it less likely that the person will bottle up their emotions as much.

Use cognitive behavioral techniques. Cognitive behavioral techniques include identifying cognitive distortions ("thinking errors" or "thinking traps") and learning how to engage in positive self-talk. They involve the realization that when we are thinking negatively or getting stuck on an inaccurate idea, that may skew our perspective. Some examples include:

- Mind reading: Thinking that we know what others are thinking about us
- Ignoring the good: Paying more attention to things that are bad
- Setting the bar too high: Expecting ourselves to be perfect
- Blowing things up: Making a small thing into a big deal

Once the student or client gains awareness of their faulty thinking, they can replace it with positive self-talk. For example, for ignoring the good, a student might say, "In my paper, I had trouble with this section, but I did a good job with explaining my argument overall." For further information, refer to the "Thinking Errors" worksheet at *therapistaid.com*.

Encourage self-compassion. Strategies that involve identifying clients' strengths and talents can help them to better understand and embrace their positive aspects. Helping students find activities in which they can really shine and develop their strengths is especially beneficial.

Safe websites that offer support

It is important to be wary of online supports for individuals who engage in NSSI. I have often encountered so-called support groups online whose members showed graphic pictures of self-injury in a sense of one-upmanship. These sites are triggering and tend to encourage further self-injury.

Over the years, I have found the following sites to be both helpful and safe:

- RecoverYourLife.com
- S.A.F.E. Alternatives recommended sites (*selfinjury.com/referrals/sites*)
- Crisis Text Line resources on self-harm (*crisistextline.org/selfharm*)

By using these strategies and resources, we can support our clients in developing new and positive coping skills. Together with their families and outside providers, we can make a difference in addressing NSSI. ❖

Lauren Appel is a behavior specialist in a North Carolina school system with a background as a school counselor. Contact her at *lauren.appel@caswell.k12.nc.us*.

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*.

American Counseling Association

Tools & Resources

For Clinical Professional Counselors

Online Learning

Earn CE credit in our online professional development programming, where you can learn in online courses, webinars, podcasts, book chapters, journal articles and practice briefs. Start exploring hundreds of learning tools.

Counseling.org/CE

Counselor Risk Management: What You Didn't Learn in Grad School That Could Lead to a Lawsuit or Licensure Board Complaint

Many ethical issues are not addressed in graduate school courses or practicum. Get real-world tips on handling ethical dilemmas to avoid malpractice and licensure board complaints.

Private Practice: The Ethics and HIPAA of Technology

Technology offers new and efficient tools to help practitioners work with clients. Learn to better understand standards of practice and ethical and legal implications of using prominent technologies, including email, texting, and distance counseling (telehealth).

Private Practice: Getting Off to a Strong Start

Opening a private practice comes with challenges. Learn to navigate tough decisions about insurance, finances, legal issues and other considerations.

Did you know...

that ACA members get FREE and DISCOUNTED education, including 12 free annual online courses ($264 value) and discounted registration to our webinars, and our annual conference and expo?

counseling.org/membership

American Counseling Association
counseling.org

That's the average cost to *defend* against a malpractice suit **($12,251)** ***plus*** the average cost of settlement payment **($101,391)** in case the claim is settled against you.*

The Counselors Professional Liability Insurance available through HPSO offers up to **$1 million** each claim (up to $5 million annual aggregate) of medical malpractice insurance, *plus* it pays your legal expenses.

- **53.7%** of malpractice claims occurred in a counselor-based office location
- **43.9%** of allegations are due to 'inappropriate sexual/romantic relationship' with the client
- **6.6%** of licensing board complaints result in loss of license
- **$7.8** million paid for counselors' malpractice claims over 5 years

Counselors Professional Liability Insurance

Call today or go online to learn more!

800.982.9491
hpso.com/preparedcounselor

HPSO®

Endorsed by:

American Counseling Association
counseling.org

When you add up all the numbers, HPSO equals *peace of mind.*

*Counselor Liability Claim Report: 2nd Edition, NSO and CNA, March 2019.

E-12288-0120